

Evaluation of the Food and Nutrition Guidelines Series



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Evaluation of the Food and Nutrition Guidelines Series

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Summary of the evaluation findings

1. Background to the evaluation

The Food and Nutrition Guidelines (the Guidelines) are currently a series of six population-specific food and nutrition guidelines documents that provide the Ministry of Health's evidence base for nutrition policy advice. The Guidelines focus on population groups throughout New Zealand with emphasis on populations most at risk, including Māori and Pacific peoples. Currently the six documents are for: Infants and Toddlers (0-2); Children (2-12); Adolescents; Pregnant and Breastfeeding Women; Adults; Older People¹. The Guidelines had been produced for almost 20 years and had never been formally evaluated.

The key objectives of the evaluation were to:

- *Determine whether the Guidelines are accessible and appropriate for the intended audience*
- *Determine if the Guidelines are fulfilling their purpose*
- *Ascertain whether the Guidelines actually inform nutrition and dietary advice, and policies in the health workforce*
- *Identify ways to enhance the process of developing the Guidelines*
- *Identify improvements and enhancements to the Guidelines to best meet the needs of the current and future health workforce*

2. Evaluation approach

Reflecting the objectives of the evaluation, the design incorporated the data collection methods set out in **Table 1**.

Table 1: Evaluation design	
Data collection medium	Information focus
<i>Literature/evidence review and analysis</i>	What's already known about effective composition and dissemination of nutrition and physical activity guidelines to public health practitioners and/or other relevant practitioners nationally and internationally
<i>Document review</i>	Information from background documents to the Guidelines (e.g. purpose and scope) and internal reviews of the Guidelines
<i>Key informant interviews</i>	Perspectives of those people who have been involved previously and recently in the development and revision of the Guidelines, including perceptions of the processes used for developing the Guidelines
<i>Stakeholder interviews</i>	Perspectives on the development, utility, effectiveness and impacts of the Guidelines from health practitioners and agencies using them
<i>E-survey</i>	Quantitative and qualitative data on issues and service impacts for health practitioners accessing and using the Guidelines

Methodological detail is provided in **Appendix 2**. The literature review referred to in this report has been provided to the Ministry earlier as a separate document.

3. Purposes of the Guidelines

The overarching purpose of the Guidelines was generally seen as providing accurate, comprehensive, evidence-based and current information to educate health practitioners and

¹ The publication of Children and Young People's (2-18 years) Guidelines will reduce the number to five documents.

other sectors on good nutrition and ideal diets specifically for New Zealanders. They believed that the Guidelines provided an ‘authoritative standard’ so that health practitioners and others would be providing consistent and accurate advice and messages to the public and colleagues.

Some key stakeholders felt that the purposes of Guidelines were not at all clear and needed to be articulated more precisely, to drive the development and revision of the Guidelines in the future. They believed that some clear decisions about the upstream and downstream goals of the Guidelines were necessary to determine their focus, content, formats, presentation, distribution and promotion.

4. Usage and uses of the Guidelines

Use of the six age-specific Guidelines documents varied significantly across the types of profession. Usage was highest overall amongst dietitians and nutritionists, and people teaching those professionals. Health promoters and community health workers tended to use the Ministry’s health education resources designed for the public to get nutrition advice rather than the Guidelines documents, as those resources were considered more appropriate for their needs. Use was more frequent for practitioners who were giving nutritional or dietary advice on a frequent basis or whose role it was to educate. Other professionals referred to the Guidelines on an “as needs” basis. Practitioners tended to thoroughly read those Guidelines that they needed most often when they first accessed them, and then “*dipped in*” thereafter to sections that they needed for a specific application.

The purposes for which the Guidelines were used most often across all professional groups were: as a standard for ensuring safe professional practice in giving dietary advice either directly or indirectly; as a reference source for nutritional and dietary information and advice; to ensure compliance with the Ministry’s advice and recommendations; for education and training purposes; for developing policy, standards and procedures; and as evidence to support submissions or lobbying.

5. Impacts of using the Guidelines

Positive changes over time that evaluation participants believed were attributable at least in part, directly or indirectly, to the Guidelines included: major time-saving for practitioners; improved knowledge of nutrition among health practitioners of all kinds; increased staff training in nutrition by PHOs and other primary care health providers; better informed practice and more consistent messages across practitioner types; a greater focus on nutrition in tertiary health education programmes; more confident advice by health practitioners; and increasing numbers of health practitioners becoming engaged in the development and revision of the Guidelines. Some participants believed that the Guidelines were being used increasingly widely as health initiatives and services have become more multidisciplinary over the past decade. The net gain of these various impacts was seen as a much greater awareness amongst all types of health practitioners of the need for attention to nutrition and the crucial role that the Guidelines have to play in addressing the rising rates of obesity, diabetes and other conditions related directly to nutrition, including eating disorders.

Positive outcomes for the general public included: (1) the availability of more accessible resources; (2) more accurate and consistent nutritional advice being given to the public; (3) a greater focus by health and education agencies on supporting nutrition initiatives and developing nutritional policies and guidelines in schools and early childhood education

centres, rehabilitation facilities, workplaces, as well as in Māori, Pacific and migrant communities.

6. Focus, scope and content

In general, survey respondents were reasonably satisfied with the relevance of the content of the Guidelines, seeing them as rightly focused on good nutrition for the New Zealand context. The main suggestions for improvement were a greater focus on food (versus nutrients), on realistic diet (versus ‘aspirational’), on enabling good nutrition and diet, on reaching as many audiences as possible (versus health practitioners primarily), and on the integration of activity guidelines with dietary guidelines. Ratings for the adequacy of the Guidelines were generally high accessibility, relevance to clients, relevance to health professions, comprehensiveness, evidence-based, ease of understanding, and referencing to information sources. Attributes that respondents rated lower were currency of the information, cultural relevance, and the practicality of the information.

Nearly half of survey respondents identified perceived gaps or inaccuracies in the information, in particular around cultural relevance and information specific to particular dietary preferences and vulnerabilities, the financial inaccessibility of many healthy foods for some population groups, and a need for better alignment of the Guidelines with activity guidelines and those for obesity and weight management. The most common suggestions for improvements were for: more frequent updating of the Guidelines; more detailed and accurate information on portion sizes; improved hyperlinking to other relevant materials and resources; more ‘budget’ nutritional advice; a more robust evidence base, based on graded evidence; recommending foods that are environmentally sustainable; and a need for ‘mythbusting’ around good nutrition.

7. Presentation

Ratings for satisfaction with the presentation of the Guidelines were reasonably high for user-friendly language, logical layout, information easy to find, the index adequate, and table of contents easy to follow. However people who had been involved in the development and redevelopment of the Guidelines believed that the current layout is not optimally user-friendly. Other attributes that survey respondents found less satisfactory were sufficient use of visual formats and culturally relevant language. Dissatisfaction around the use of culturally relevant language and examples was common across most professional categories and especially amongst people in Māori and Pacific health, maternity services, and primary and secondary education.

The common theme amongst participants’ suggestions for change to the Guidelines was around making the content more accessible to the full range of health practitioners, to encourage uptake of more of the information in the Guidelines and facilitate easy use of the material. The main suggestions for improvements were: greater use of visual formats rather than narrative text; greater use of formatting to highlight information; more ‘modern’ presentation; more user-friendly, contemporary, “personal” language; increased use of language, references, information and examples relevant to Māori and cultures other than Pākehā and European cultures; pictures of portion sizes; avoidance of vague terms that remain open to wide interpretation; and having the Guidelines available in Word as well as PDFs, so that information can be readily copied.

8. Distribution and accessibility

Knowledge of how to access the Guidelines amongst those who were aware of them was high for dietitians, nutritionists, midwives and lactation consultants, nurses and academics/researchers, but relatively poor for GPs, health promoters, health educators/teachers and community health workers. Paper copy was the usual access medium of 63% and electronic used by 53%, with 19% using both media. However when asked what their preferred medium was, only 40% said paper. Electronic access was a preferred medium of 60%, with 20% wanting the Guidelines available to them in both paper and electronic form. Where people wanted paper copy to continue to be made available, the reasons boiled down to cost or not having access to a quality printer. The main issue identified with distribution was the cost of printing and despatching paper copies.

Suggestions for improvement focused on; supporting people to use electronic documents; providing the Guidelines in formats that can be printed cheaply; determining ways to make paper copy either unnecessary or less expensive to produce; diversifying formats and media for greater accessibility; a dedicated website; use of the social media for distribution and promotion; and alignment with a promotions strategy for the Guidelines.

9. Awareness and promotion

Awareness of the Guidelines varied across professions and sectors, based partly on the extent to which nutritional advice was seen as a core part of each profession's work. However awareness also varied within professions, depending on particular roles, the philosophy of the agency, or even personal views of the importance of nutrition versus other aspects of well-being. Many survey respondents believed the Guidelines are not sufficiently promoted, either within the health professions or across other sectors. The main suggestion for improvement was to develop a comprehensive promotions strategy for the Guidelines – identifying key target audiences, determining the most effective strategies and techniques to promote the Guidelines to each audience, and then exploring 'smart' ways to use the various media available to reach each of those audiences cost-effectively, including both 'push' and 'pull' strategies (that is, focusing on ways that the Guidelines can be used to enhance professionals' job satisfaction and /or improve client outcomes with least effort or intervention).

10. Compilation and review of the Guidelines

A majority of survey respondents were either not familiar with the process for reviewing the Guidelines (58%) or unsure if they knew about it (6%). Of those who were aware of the Guidelines review process, 41% overall had made a submission at some time and three quarters of those had found that process useful. The review process was widely seen as too long in its current form, resulting in outdated information in the Guidelines. Many evaluation participants believed that too much of the available budget was being spent on the review process currently, rather than on the contents, presentation and promotion of the Guidelines. The most common barriers to participating in the review process were that people were not aware of a review occurring, they did not have enough time to make a written submission, and/or the agency could not afford to pay someone to make a well considered, evidence-based submission. Many respondents felt it was unnecessary for them to submit when their professional body was doing so.

Survey respondents were almost equally divided as to whether a public consultation process was necessary – 41% 'yes' and 38% 'no', with a further 21% 'not sure'. A majority of

interview participants believed that a full public consultation was not necessary, especially balanced against the time and costs involved, as long as it were replaced by a robust and representative stakeholder consultation. Many interview participants saw the current management and governance structures as lacking effectiveness, in particular that (1) the project management role is too large, too complex, has too many responsibilities, is susceptible to personal bias and isolated, and that (2) there is insufficient structured governance for the project. Specific suggestions were made for improving the Guidelines review processes, including governance and management.

11. Cost-effectiveness

Cost-effectiveness of the Guidelines is difficult to assess without comprehensive budget and benchmarking information. Confidential information on ballpark costs was obtained from only one overseas agency and has been provided to the Ministry separately. Evaluation participants were not able to identify another set of guidelines developed in New Zealand that they saw as similar in scope to the Food and Nutrition Guidelines for benchmarking purposes. However there was a widespread perception that there were some high-cost activities in the development of the Guidelines that might be undertaken at a lower cost, thus freeing up funds for other features. Costly activities that might be obviated were the extensive paper distribution of the draft and complete Guidelines, the double peer review process, and undertaking a comprehensive evidence review, versus purchasing that information from overseas or co-funding through a collaboration with an overseas agency. Evaluation participants identified viable alternatives to those processes and several areas where funds might be spent to greater effect.

12. Future directions

The evaluation findings indicate that the Guidelines are valued highly by the broad range of health practitioners who use them and are seen by many as essential to safe practice for all health practitioners who provide advice or education in nutrition. Evaluation participants were unanimous in their view that the Guidelines need to be retained, albeit in a form that is more accessible to the range of health practitioners and others and updated more frequently. Typical feedback from evaluation participants was that the Guidelines would be improved by a comprehensive revision of the following parameters: focus and content; formats, layout and presentation; review processes; distribution and promotion; management and governance structures; and a clearer understanding of their purposes and goals. A model is proposed (chapter 12) that was seen by a majority of stakeholders as a potentially significant improvement on the current Guidelines and likely to reduce or avoid many of the current issues with the features and development of the Guidelines. The key features of the suggested model were as follows:

- Restructuring the Guidelines into one key document supported by a cluster of other documents, as has been done in the US and Australia
- Focus the key document on highly visual, practical dietary information that is focused on food (versus nutrients) and on enabling good nutrition
- Support documents would include:
 - ✧ A background document with the evidence base on the technical and clinical aspects of nutritional and dietary advice
 - ✧ A cluster of short papers that set out information for specific populations based on demographics (age, culture) and other relevant parameters (e.g. disability, medical conditions, dietary preferences [e.g. vegan, kosher, halal])

- ✧ A range of publications via multiple media, as appropriate to target audiences, with resources aimed at the general public and professionals across all relevant sectors (e.g. healthy plates; menus; recipes; weight management advice; resources of various kinds; hyperlinks to a broad range of online resources)
- Consultation with relevant stakeholder agencies for best collaborative use of the budgets available and to build on one another's work
- A Steering Group comprising relevant key stakeholder representatives, meeting regularly to determine the direction and scope of Guidelines development
- Move to a primarily or totally online distribution system
- Development of a separate website for the Guidelines
- Development of a comprehensive distribution and promotions strategy

Section A. Evaluation purposes and approach

1. Background to the evaluation

The Food and Nutrition Guidelines Series

The Food and Nutrition Guidelines (the Guidelines) are currently a series of six population-specific food and nutrition guidelines background papers that provide the Ministry of Health's evidence base for nutrition policy advice. Guidelines focus on population groups throughout New Zealand with emphasis on populations most at risk, including Māori and Pacific peoples. Currently the six documents are:

- Infants and Toddlers (0-2)
- Children (2-12)
- Adolescents
- Pregnant and Breastfeeding Women
- Adults
- Older People

Following a recent review and updating of guideline documents for Children (2-12) and for Adolescents and a public consultation, it is intended that there will be five rather than six population-specific Guidelines with the publication of Children and Young People's (2-18 years) Guidelines.

The Guidelines have been produced for almost 20 years and aim to provide up-to-date, evidence-informed policy advice and technical information for health practitioners working with the public to achieve a healthy lifestyle, including nurses, dietitians, doctors, nutritionists, health promoters and educators. Each Guidelines document has a complementary health education resource for the general public. As healthcare delivery develops due to new technologies and population changes, it is critical that the Guidelines meet current and future needs of the health sector including the needs of health practitioners and the general public. While the Guidelines have never been formally evaluated, some of the health education resources have been.

Key evaluation objectives

The key objectives of the evaluation were to:

- *Determine whether the Guidelines are accessible and appropriate for the intended audience*
- *Determine if the Guidelines are fulfilling their purpose*
- *Ascertain whether the Guidelines actually inform nutrition and dietary advice, and policies in the health workforce*
- *Identify ways to enhance the process of developing the Guidelines*
- *Identify improvements and enhancements to the Guidelines to best meet the needs of the current and future health workforce*

The Ministry sought the following evaluation components:

Process evaluation

1. To provide feedback on Guidelines development for the purposes of fine-tuning the on-going and future development of guidelines and resources in the health workforce

2. To support on-going planning and stakeholder consultation processes

Outcome/impacts evaluation

3. To assess (1) the accessibility of the Guidelines for the target audience of health practitioners and their effectiveness in line with intended purpose, (2) the utilisation of the Guidelines and impacts (e.g. changing of workplace policies for health practitioners), and (3) provide information to inform the future development of the Guidelines.

The detailed areas of inquiry are set out in **Appendix 1**.

2. Evaluation approach

Mixed method evaluation

Reflecting the objectives of the evaluation, the design incorporated the data collection methods set out in **Table 1**. Data collection was undertaken in roughly the order shown in **Table 1**, with some overlap in timing.

Table 1: Evaluation design	
Data collection medium	Information focus
<i>Literature/evidence review and analysis</i>	What's already known about effective composition and dissemination of nutrition and physical activity guidelines to public health practitioners and/or other relevant practitioners nationally and internationally
<i>Document review</i>	Information from background documents to the Guidelines (e.g. purpose and scope) and internal reviews of the Guidelines
<i>Key informant interviews</i>	Perspectives of those people who have been involved previously and recently in the development and revision of the Guidelines, including perceptions of the processes used for developing the Guidelines
<i>Stakeholder interviews</i>	Perspectives on the development, utility, effectiveness and impacts of the Guidelines from health practitioners and agencies using them
<i>E-survey</i>	Quantitative and qualitative data on issues and service impacts for health practitioners accessing and using the Guidelines

Methodological detail is provided in **Appendix 2**. The literature review referred to in this report has been provided to the Ministry earlier as a separate document.

Stakeholder interviews

Interviews were held with 55 people in total, representing: current and previous Ministry personnel with responsibility for the Guidelines; people who had been contracted to draft the Guidelines documents; representatives of professional associations, advisory groups, health provider agencies, tertiary institutions teaching dietitian and nutritionist qualifications; and four health practitioners who identified themselves as using the Guidelines less than once a year (a pharmacist, a midwife, a personal trainer and a community health worker, all based in the Auckland region). A full breakdown of those interviewed is provided in **Table 2, Appendix 2**.

Survey response

Total survey response was 997 (though the total response base varied across questions; responses across professions are set out in **Tables 3 and 4, Appendix 2**). There was a very large response (26% of total) from retail pharmacists – almost twice as large as any other group. Generally pharmacists' responses indicated a strong interest in the Guidelines, which a majority were unaware of prior to undertaking the survey. (Note that this disproportionate response rate reduced dramatically from Q6 onwards where only those previously familiar with the Guidelines continued the survey to provide feedback on the Guidelines.) The next largest survey response rates were from dietitians (14% of total) and health promoters (13%), followed by community health workers, nurses, nutritionists and academics/researchers (5-7% each), doctors, midwives and educators/teachers (3-4% each),

and a minimal response from dental professionals and fitness trainers².

There were twice as many responses from the Auckland District Health Board (20%) as any other DHB. Representation from other DHBs was:

- 9-10% each from Canterbury, Waikato and Capital and Coast.
- 5-6% each from Hawkes Bay, Southern, Bay of Plenty, MidCentral, Waitemata and Counties Manukau.
- 3-4% each from Taranaki, Hutt Valley, Northland, Tairāwhiti and Nelson Marlborough.
- 1-2% each from Lakes, Wanganui, Wairarapa and South Canterbury; less from West Coast.

Respondents were 68% Pākehā, 18% Māori, 7% Pacific, 6% Asian, 1% African/Middle Eastern/Latin American, and 8% 'other' (the majority of these were European). This ethnic spread roughly reflects that of the general population.

Half of respondents had worked in the health sector for more than 10 years, and a further third for 3-10 years. Only 14% had been in the sector for less than two years.

Limitations of the method

The only significant limitation of the method related to the recruitment for the survey. In the absence of a suitable existing database of health practitioners who might be expected to use the Guidelines, survey recruitment was undertaken by identifying the professional associations of relevant health practitioners and asking for their assistance to disseminate an invitation to members to complete the survey. This approach relied on (1) the associations being willing to assist and (2) individual contact people within each association all being available at the same time to disseminate the invitation. As a result, the dissemination process was less than perfect. It also meant that it was not possible to estimate proportions of each profession responding to the survey. However the response to the survey was very high (n=971) and provided a wealth of quantitative and qualitative information from across the targeted health practitioner types (see **Tables 3 and 4, Appendix 2**) that was consistent with the information obtained through the other data collection methods used. Moreover the mixed method approach ensured robust triangulation and mitigated the limitations of the survey sample.

The report

Integration of findings

The report integrates information gained through the various data collection methods and from the whole range of stakeholders. Where any stakeholder group held views at variance from those of others, that is stated. In general there was a high level of consensus across stakeholder groups. Quantitative data (from the survey) have been used to give a clear indication of the relative importance of the range of stakeholder uses, preferences and suggestions for improvements to the Guidelines. Where reported data are statistically significant that is stated³.

² Fitness New Zealand and the New Zealand Dental Association did not distribute the survey invitation.

³ Much of the data could not be tested for statistical significance at a reliable level because 'cell' numbers were less than 30.

Terminology used

Terminology for the qualitative components of the evaluation (that is, all data except from the surveys) that refers to numbers of participants representing a particular view or experience is as follows: ‘some’ refers to 2-4 people; ‘several’ refers to 5-7 people; ‘many’ refers to 10 or more people; larger numbers are described as a proportion of the stakeholder group referred to (e.g. ‘a majority’, ‘more than half’).

For the avoidance of confusion:

- ‘Evaluation participants’ refers to *all* people who took part in the evaluation
- ‘Interview participants’ refers to those people who were interviewed
- ‘Survey respondents’ and ‘respondents’ refers to people who responded to the survey

Use of quotes

Quotes have been presented verbatim to ensure that participants’ views are accurately represented, including the intensity of those views. They have been selected to be representative of the views of the stakeholder group named. To avoid identifying individual evaluation participants, most verbatim quotes are attributed to the speaker’s stakeholder group with minimal additional description (e.g. ‘dietitian’, ‘Ministry personnel’, ‘professional association’). Additional description has been added where it is important to distinguish some attribute relevant to the quote (e.g. experience in the health sector; ethnicity).

Authorship

All members of the evaluation team were involved in the writing of this report, and its contents reflect the integration of data from the various data collection methods used.

Section B. Uses and value of the Food and Nutrition Guidelines

3. Purposes of the Guidelines

Summary

The overarching purpose of the Guidelines was generally seen as providing accurate, comprehensive, evidence-based and current information to educate health practitioners and other sectors on good nutrition and ideal diets specifically for New Zealanders. They believed that the Guidelines provided an ‘authoritative standard’ so that health practitioners and others would be providing consistent and accurate advice and messages to the public and colleagues. Some key stakeholders felt that the purposes of Guidelines were not at all clear and needed to be articulated more precisely, to drive the development and revision of the Guidelines in the future.

Users’ perceptions of the purposes of the Guidelines

The introductory material in the various Guidelines documents typically describes them as “*provid[ing] up to date, evidence based policy advice to be used as a best practice guide for ensuring optimal nutrition in [population age group] by health practitioners – including dietitians, nutritionists, doctors, nurses, primary health care providers, aged-care workers, and health promoters*”. Not surprisingly, then, the overarching purpose of the Guidelines was generally seen by health practitioners as providing accurate, comprehensive, evidence-based and current information to health practitioners and other sectors on good nutrition and ideal diets specifically for New Zealanders. This purpose was seen by evaluation participants as having six key components, as follows:

- To provide a single ‘*authoritative standard*’, so that health practitioners and others would be providing *consistent and accurate* advice and messages to the public and colleagues. It was seen as vital that the government took a lead in this way, to ensure that the advice given was non-partisan and not biased by stakeholders with vested interests.

“Otherwise each university may have one and the food industry could create their own”. Nutrition lecturer

- To gather all nutritional *information and advice together in one place*
- To ensure health practitioners are using *comprehensive and current knowledge* to inform their advice and practice generally
- To provide *resources for health practitioners*, to obviate them having to undertake their own research or compile their own materials
- To ensure that *advice is relevant to New Zealand populations*, in the context of unique factors such as cultural make-up, health and socioeconomic trends, and soil types
- To *increase and facilitate nutritional knowledge amongst health practitioners* and others who do not either specialise or have a tertiary qualification in that area.

Few evaluation participants saw the Guidelines as providing policy as such; rather they saw the Guidelines as providing standards based on information that could be trusted by health practitioners as ‘best practice’ for New Zealand’s various sub-populations.

Uncertainty around the purposes of the Guidelines

Several participants, in particular people who had been involved in various roles in the

compilation and revision of the Guidelines over the past ten years, felt that the purposes of Guidelines were not at all clear and needed to be articulated more precisely, to drive the development and revision of the Guidelines in the future. These people pointed out that there are no clearly set out outcomes goals for the Guidelines. As a result there is confusion as to whether the Ministry is in fact attempting to establish policy as such, as distinct from guide good practice for health practitioners. Without clear outcomes goals for the Guidelines, it was felt that they ran a risk of trying to “*be all things to all people*”, when that might not be necessary, desirable or feasible. Participants identified the following range of purposes for the Guidelines, and queried which of them the Guidelines were intended to fulfill:

- Set or state or apply policy, and if so, whose policy (e.g. the Ministry’s, or the current government’s)?
- Set nutritional standards
- Educate health practitioners generally
- Be an educational resource for teaching health practitioners
- Be an educational resource for health practitioners to use with clients – and if so, for which professions?
- Provide practical advice to health practitioners, and which ones?
- Provide practical advice to other professionals, and if so, in which sectors?
- Provide advice to the general public, and if so which sectors, given diverse cultures, languages and educational levels
- Promote healthy lifestyles
- Educate the general public about good nutrition
- Address the obesity and diabetes ‘epidemics’.

“If it’s about behavioural change, I don’t know if the Guidelines’ purpose or goal is being met.” Fitness industry

“It [rewriting the Guidelines] was a tough process, and often the point of it all got lost...” Contracted writer

These participants believed that some clear decisions about the upstream and downstream goals of the Guidelines were necessary to determine their focus, content, formats, presentation, distribution and promotion.

“They’ve been doing them for years now, so they just go on doing them. It’s time to get clear about what they’re really for.” Ministry personnel

4. Usage and uses of the Guidelines

Summary

Use of the six age-specific Guidelines documents varied significantly across the types of profession. Usage was highest overall amongst dietitians and nutritionists, and people teaching those professionals. Health promoters and community health workers tended to use the Ministry's health education resources designed for the public to get nutrition advice rather than the Guidelines documents, as those resources were considered more appropriate for their needs. Use was more frequent for practitioners who were giving nutritional or dietary advice on a frequent basis or whose role it was to educate. Other professionals referred to the Guidelines on an "as needs" basis. Practitioners tended to thoroughly read those Guidelines that they needed most often when they first accessed them, and then "dipped in" thereafter to sections that they needed for the specific application. It was apparent from integrating the interview and survey data that the purposes for which the Guidelines were used most often across all professional groups were: as a standard for ensuring safe professional practice in giving dietary advice either directly or indirectly; as a reference source for nutritional and dietary information and advice; to ensure compliance with the Ministry's advice and recommendations; for education and training purposes; for developing policy, standards and procedures; and as evidence to support submissions or lobbying.

Usage of the six Guidelines

General usage patterns

Survey respondents⁴ were asked to identify which of the Guidelines they used most often, how often they used that document in the past 12 months, and how much of it they had read. In summary:

- Overall, the rates of usage in the last 12 months (among people who knew how to access the Guidelines) were greatest for the Guidelines for adults (51% of survey respondents), followed by those for children (43%), breastfeeding women (41%), infants and toddlers (37%), older people (34%), and adolescents (27%).
- While professionals of all types surveyed were using all of the Guidelines to varying degrees, use of particular Guidelines varied significantly across the types of profession, as might be expected.
- Amongst the figures for most frequent usage within the past 12 months: 96% of midwives and lactation consultants had used the breastfeeding Guidelines; 84% of nutritionists, 77% of dietitians and 69% of those in tertiary education had used the Guidelines for adults; 67% of GPs had used the Guidelines for infants and toddlers; and around 60% of nurses had used the Guidelines both for children and for infants and toddlers. Dietitians and nutritionists used the Guidelines generally significantly more often than any other profession.
- Between 40-50% of dietitians and nutritionists had used *all* of the Guidelines within the past year, and usage in these professions was up to 84% for particular Guidelines, especially those for adults.
- Pharmacists used the Guidelines for adults and breastfeeding women more often than the other Guidelines.
- Although health promoters and community health workers indicated usage of all of the

⁴ Number of respondents for each survey question are set out in **Table 5, Appendix 2**.

Guidelines, usage was at rates lower than 50%; however the evaluation interviews revealed that these professionals tended to use the Ministry's health education resources designed for the public rather than the Guidelines documents, because they were easier to understand, less time-consuming to read and more appropriate for their needs.

- Use of the Guidelines within particular health services contexts also varied widely. While no clear patterns emerged, significantly higher use of the Guidelines for adolescents was apparent in public health and tertiary education; those for breastfeeding women in maternity services, primary care, tertiary education and pharmacy; those for children in public health; those for older people in hospitals and by dietitians; those for infants and toddlers in primary care and by nurses; and those for adults by nutritionists and in Pacific health and tertiary education.

Frequency of usage

Practitioners' actual use of the Guidelines that they referred to most often showed a pattern where a majority (57%) referred to the Guidelines once every 1-3 months, 22% used them around once a month, and the remainder only once or twice a year. Usage of the Guidelines for toddlers and infants and those for adolescents tended to be more frequent overall than the other Guidelines. Comments from evaluation participants suggested that use was more frequent for practitioners who were giving nutritional or dietary advice to clients or colleagues on a frequent basis, or whose role it was to educate students, colleagues or others. These practitioners needed detail more often than others, because their advice was often tailored to the needs of a specific person or organisation. Others referred to the Guidelines on an "*as needs*" basis.

Extent of Guidelines information read

- The survey data indicated that health practitioners tended to read a majority of the information in the Guidelines document that they used most often. Across all survey respondents, 59% said that they had read "*most*" of that document, and a further 26% had read "*about half*" of the document. Only 15% had read less than a half of the information in the document.
- The emerging survey pattern, confirmed in the evaluation interviews, is that professionals tended to thoroughly read those Guidelines that they needed most often when they first accessed them, and then "*dipped in*" thereafter to only those sections that they needed for the specific client or occasion.
- Many practitioners commented that they read the Guidelines "*pretty much cover to cover*" when a revised edition was published, because they saw the document as containing "*completely up-to-date information*", and thus treated it as the definitive evidence or guidance for their practice and a way to update their own knowledge "*without having to read all the research yourself*".
- Usage among interview participants tended to be more comprehensive for professionals working with vulnerable populations such as frail elders and infants and toddlers, and for those whose professions are readily subject to media attention when mistakes are made (e.g. midwifery and general practice). For example, some midwives said that they read the Guidelines for pregnant and breastfeeding women "*cover to cover*".

"I read it all and I read it often – I want to know that my advice is totally backed up."
Midwife

Value and uses of the Guidelines

Value of the Guidelines

Evaluation participants' perceptions of the real value of the Guidelines represented five key assets:

- The Guidelines are seen as **authoritative** – Because they are compiled and published by the Ministry of Health and are described as evidence-based, they “*give ‘authority’ to the information and to the recommendations being made*” by the whole range of health practitioners, including those who do not have tertiary qualifications. As a consequence health practitioners felt safe using the Guidelines to give advice to clients, colleagues and others, knowing they were adhering to a government publication that purports to be comprehensive, evidence-based and up-to-date.
- The information is handy because it is **comprehensive, structured and all in one place** – a “*one-stop-shop*” for health practitioners and others seeking accurate and trustworthy information and advice, that saves people time and effort. This accessibility means that health practitioners have the information that they need to give to clients at their fingertips, saving precious time.
- The Guidelines are a **vital teaching and learning resource**, for a wide range of tertiary programmes, schools, for in-house training by health providers, for developing educational resources, and for individual practitioners wishing to be well informed.
- They are also an **essential guide to everyday practice** – Many dietitians and nutritionists use them as the foundation text for their practice, and they are used the same way by community health workers and others designing and providing healthy eating programmes and dietary advice to a broad range of population groups.
- The information is **free** – Neither practitioners nor the public have to pay for it. Many participants felt that this was an essential public service and a fundamental responsibility of government.

“If you are in the nutrition sector, the information contained in the Guidelines were drummed into you from uni.” Nutrition advisor

In summary, health practitioners assume that the information in the Guidelines is accurate, up-to-date, comprehensive and reliable. As a consequence they believe that they are practising safely if they rely on the Guidelines.

“They are a standard for schools. Most people feel they know what is healthy or not, however the Guidelines are evidence-based and not based on people’s prejudices or preconceptions.” Survey respondent

“There’s a huge amount of information all in one place and I don’t have to check to see if it’s accurate, because it’s published by the Ministry.” Dietitian

“It means that we’re all [range of health practitioners] giving our patients consistent messages, and that’s really important.” Professional association

What makes the Guidelines effective for users?

Participants identified the following main features of the Guidelines as essential to make them effective.

- ***Currency of the information through regular revision and updating*** – While this requirement applied primarily to information that was susceptible to change in a short time frame, trends in populations, health, environment and economics meant that it was important that the Ministry keep a close watch on those trends to identify changes in the evidence.
- ***Applying the evidence base stringently*** – Ensuring that the information in the Guidelines has a sound evidence basis was pivotal to users' ability to trust the Guidelines as accurate and feel confident to use them. Achieving this meant that a high standard of what constitutes 'evidence' needed to be applied.
- ***Comprehensive coverage of topics related to nutrition to ensure relevance to the broad range of health practitioners*** – Comprehensiveness was essential not only to ensure that relevant information was available for all types of health practitioners (and other professions able to influence public health), but also to ensure that those various professions were giving consistent messages to the public.
- ***The claim to be authoritative*** – Setting the Guidelines out as a set of standards was essential to avoid sectors with vested interests, in particular the food industries and other lobby groups, were not providing misleading information to the public, and in particular to populations at risk of poor health outcomes.
- ***Comprehensive and representative input into the Guidelines' development*** – Representative input was important both to ensure that the Guidelines contained information relevant to all population groups and also to facilitate buy-in from the broad range of health practitioners.
- ***Practical utility*** – The more immediately applicable the information in the Guidelines was to everyday uses for health practitioner, the more likely they would be used.

These features in combination were seen as the source of the *trustworthiness* of the Guidelines that makes them valuable. Missing any one of those features would reduce their trustworthiness and make health practitioners feel less confident to use them and/or less safe in their practice when using them. Many survey participants expressed concern at learning in the survey that the Guidelines are revised only every 10 years or so, commenting that it made them concerned that they might not be giving safe advice when using them. More frequent updating was the most common suggestion for improvement to the Guidelines (see pp 25-26).

“Having a volume of information available online and in print is very valuable simply to keep my practice safe and up to date as an RN working in isolation in the community. It is really important when we are not affiliated with a DHB and work in the community educating staff and giving advice and support for people with special needs that this sort of document is available to us easily and simply.” Community nurse

“If we didn't have them [the Guidelines], there would be a huge vacuum... it would be awful, uncomfortable...” Professional association

Two key challenges emerged to achieving all of the features outlined above: *firstly*, the tension between updating information quickly and obtaining comprehensive and representative input from across the health professions and other interested sectors (e.g. consumer advocacy groups); and *secondly*, finding a balance between including comprehensive information for various population groups and making the Guidelines so

long and detailed that they lose ready applicability. These issues are discussed in Chapters 6-8.

Range and types of uses

Most common uses

It was apparent from integrating the interview and survey data that the purposes for which the Guidelines were used most often across all professional groups were as a ***standard for ensuring safe professional practice*** in giving dietary advice either directly or indirectly. The Guidelines were used intensively by professionals and agencies whose role it was to give dietary and nutritional advice to professionals, colleagues, students or the public at large. The following uses were identified most often across all of those surveyed and interviewed.

1. As the ***reference source*** for nutritional and dietary information and advice – The reference function of the Guidelines was identified as a main use by all interview participants and 53% of total survey respondents, including all types of health practitioners and in all areas of work. Common uses across health practitioners and others were developing resources (dietary guidelines, protocols, pamphlets), such as for:
 - ✧ Work place (e.g. canteen menu development)
 - ✧ Work groups (e.g. toolkits for community health workers)
 - ✧ Early childcare education (e.g. appropriate weaning or toddler foods)
 - ✧ Schools (e.g. tuck shops)
 - ✧ Migrants (e.g. understanding food labels; nutritional New Zealand food equivalents for traditional foods)
 - ✧ Māori (e.g. for kaumātua health programmes; guidelines for health workers)
 - ✧ Pacific (e.g. working with the churches on health programmes)
 - ✧ Professions (e.g. guidelines for practitioners developed by professional associations)
 - ✧ Publications put out by agencies involved in nutrition (e.g. Agencies for Nutrition Action, Health Sponsorship Council, Heart Foundation), including social marketing (e.g. radio and TV commercials)
 - ✧ Direct advice to the public (e.g. pharmacists seeking information about nutrient values against which to assess food supplements or subsidised prescription food)
 - ✧ Public education resources (e.g. handouts for participants in health programmes, such as the HEHA⁵ suite of programmes)

“It [referring to the Guidelines] saves having to do a big confusing review of all the research, which is a bit beyond my skills even if I had the time. The sector’s plagued with inconsistent advice and information...” Dietitian

2. ***Referring others to accurate nutritional information*** – 49% of survey respondents and the majority of interview participants used the Guidelines as reference documents to which they referred clients, colleagues and others for information. Reasons that practitioners referred people to the Guidelines were typically: to substantiate their own views, information or advice; when people wanted more detailed information; to save time in explaining information (e.g. to students or colleagues); and because they believed that the Guidelines explained the information more clearly or in more detail than the practitioner could.
3. As ***the standard for accurate information*** on nutrition and diet – Checking on the

⁵ The former Healthy Eating Healthy Action suite of programmes, such as the Green Prescription, Kapai Kai and Healthy Village Action Zone programmes.

accuracy of one's knowledge was identified as a main use by 47% of survey respondents, and the majority of interview participants stated or alluded to this function of the Guidelines as being a major use. Having a knowledge standard was seen as vital in the context of myriad competing and often conflicting voices from research, lobbies, interest groups and the food industry. Many evaluation participants identified the Guidelines as a "*safety net*" or the basis of "*safe*" practice for any professional giving advice or making recommendations around diet. Common uses of the Guidelines as knowledge standards were:

- ✧ "*Double-checking*" on the accuracy of advice health practitioners were giving out
- ✧ For professional education from undergraduate to certification programmes
- ✧ Community programme planning (e.g. HEHA programmes and similar)
- ✧ Food labelling
- ✧ Inclusion as a specification in contracts for services (e.g. with the Ministry of Health, DHBs and PHOs)
- ✧ To support research
- ✧ As supportive evidence in conference presentations.

These top three uses (as numbered above) were identified commonly (50-80%) by the majority of health professionals, including educators, though less often by academics/researchers, pharmacists and GPs. A *fourth* common use - ***ensuring one's compliance with the Ministry's advice and recommendations*** – was indicated by 43% of survey respondents, especially nurses, dietitians and nutritionists, health educators and midwives. Interview participants in these professions highlighted the potential for serious professional culpability were they to make a mistake in their advice. Compliance was indicated least often in the survey by pharmacists, GPs, academics/researchers, and least of all by people working in Pacific health.

"I tell people 'The Ministry guidelines say...', and I can be reasonably confident that they'll take some notice..." Dietitian

Other important uses

- The Guidelines were used by 29-35% of survey respondents for ***education and training*** purposes, typically undergraduate and postgraduate education, on-the-job staff training, continuing education for practitioners, training courses and induction for people moving into the health professions. In some of these contexts one or more of the Guidelines documents would be used as a text.
- 20% of survey respondents had used the Guidelines for ***developing policy, standards and procedures***, especially in public health and Māori and Pacific health. Typically these uses involved either taking information directly from the Guidelines and incorporating them verbatim into agency documents and/or using the Guidelines information as a basis for the agency document.
- 14% of survey respondents had used them as evidence ***to support submissions or lobbying***, in particular nutritionists, educators and people in Pacific health. In this context information was taken from Guidelines as evidence supporting particular claims or recommendations, and it was important for users that the Guidelines information be reliably current.

In all three of these contexts, the Guidelines were referred to *because* they were seen as constituting an authoritative standard.

Other uses of the Guidelines that a few respondents identified were for respondents' own study and assignments and giving information advice to friends and family.

Most valuable areas of information in the Guidelines

Survey respondents gave a very wide range of answers to the question around which information in the Guidelines was most valuable to them, and many respondents simply said "*all of it*". However some patterns did emerge, with respondents identifying the following areas of information as having particular value:

- ***Advice on portion size*** was used by a wide range of practitioner types in a variety of media, with individual clients and in advisory publications.
- Having access in the Guidelines to ***practical information and advice***, such as sample meals, was greatly valued by all health practitioners dealing directly with the public.
- ***Guidance for managing obesity*** was mentioned by many participants as an increasing need.
- ***Information for specific population groups*** that an individual practitioner may not deal with often was especially valued, including diverse cultures, ages, people with various medical conditions, and people requiring special diets.
- The ***basic information on required nutrients and required nutrient levels*** was invaluable to dietitians, nutritionists and medical practitioners.
- ***References in the Guidelines to other sources of information*** and more detailed or specialist information was valued where practitioners wanted a deeper understanding of the advice given in the Guidelines.
- Providing ***information on activity and fitness*** in the Guidelines saved practitioners time and effort by not having to seek that information in another resource.
- ***Information presented in tables, graphs and other visual formats*** was found easier to understand and also useful for giving to clients and students.
- ***Providing a clear policy stance on controversial issues*** helped practitioners in covering those issues with clients and others.

A pattern emerging from this feedback is that health practitioners value the Guidelines because they provide an answer when practitioners are faced with a scenario that is outside of their previous or recent experience and range of expertise.

5. Impacts of using the Guidelines

Summary

Positive changes over time that evaluation participants believed were attributable at least in part, directly or indirectly, to the Guidelines included: major time-saving for practitioners; improved knowledge of nutrition among health practitioners of all kinds; increased staff training in nutrition by PHOs and other primary care health providers; better informed practice and more consistent messages across practitioner types; a greater focus on nutrition in tertiary health education programmes; more confident advice by health practitioners; and increasing numbers of health practitioners becoming engaged in the development and revision of the Guidelines. Some participants believed that the Guidelines were being used increasingly widely as health initiatives and services have become more multidisciplinary over the past decade. The net gain of these various impacts was seen as a much greater awareness amongst all types of health practitioners of the need for attention to nutrition and the crucial role that the Guidelines have to play in addressing the rising rates of obesity, diabetes and other conditions related directly to nutrition, including eating disorders. Positive outcomes for the general public included (1) the availability of more accessible resources and (2) more accurate and consistent nutritional advice being given to the public, together with (3) a greater focus by health and education agencies on supporting nutrition initiatives and developing nutritional policies and guidelines in schools and early childhood education centres, rehabilitation facilities, workplaces, as well as in Māori, Pacific and migrant communities.

Evidence of impacts

None of the interview participants was able to point to any robust data on the impacts of the Guidelines or knew of any research that had measured impacts systematically. However all were able to provide their perceptions of ways in which the Guidelines had made a difference, and some themes also emerged from the survey responses.

Impacts for health practitioners

Many participants had seen positive changes over time that they believed were attributable at least in part, directly or indirectly, to the Guidelines, as follows:

- **Major time-saving** for practitioners as a result of having the Guidelines information so readily available in one place
- **Improved knowledge of nutrition** generally among health practitioners of all kinds, in particular practitioners who might not otherwise provide nutritional advice (e.g. GPs, hospital nurses and allied staff, and dentists)
- **Increased staff training in nutrition** by PHOs and other primary care health providers
- **Better informed practice** by health practitioners, and more consistent messages across practitioner types
- **Greater focus on nutrition in tertiary health education programmes**, due to the availability of the Guidelines as a text
- **More confident advice by health practitioners**, relying on the Guidelines as a set of standards
- **Increasing numbers of health practitioners becoming engaged** in the development and revision of the Guidelines. Many evaluation participants congratulated the Ministry for

undertaking the present evaluation and ensuring a broad health sector engagement in it through the survey.

Some participants believed that the Guidelines were being used increasingly widely as health initiatives and services have become more multidisciplinary over the past decade.

The net gain of these various impacts was seen as a much greater awareness amongst all types of health practitioners of the need for attention to nutrition and the crucial role that the Guidelines have to play in addressing the rising rates of obesity, diabetes and other conditions related directly to nutrition, including eating disorders.

Example:

Under the umbrella of Healthy Village Action Zones, an initiative run by the Tongan Health Society and funded by the Ministry of Health and the Auckland District Health Board, a nutritionist has used the Guidelines as the basis for training to successfully build Pacific community capacity through training Pacific Church Health Committees in healthy eating and nutrition. The initiative – Community Nutrition Training (CNT) – is provided in partnership with Pacific Heartbeat and has used the Guidelines extensively. It offers a two-day course covering ‘Introduction to Food and Nutrition’ and a nine-day course which covers ‘Food and Nutrition’ in greater depth. The results of the initiative to date are impressive – of 42 Pacific churches in Auckland, 38 now have CNT graduates. There are 112 graduates of the two-day CNT programme and 17 graduates of the nine-day CNT programme. To ensure that graduates’ knowledge is structured into the churches’ programmes, the churches have been supported to develop policies around nutrition. CNT maintains contact with the churches to support their implementation of those policies and gives awards to churches that have achieved three healthy eating goals with their congregations. Now the majority of Pacific churches in the Auckland area have water fountains, grants for fruit for Sundays, and weight scales.

Impacts for the general public

Evaluation participants who identified positive impacts of the Guidelines for health practitioners also saw positive outcomes for the general public, in particular:

- More and better resources being developed for various sectors of the public due to the availability of well summarised information in the Guidelines
- An increasing number of publications on healthy food being made available to the public via a range of media
- More accurate and consistent nutritional advice being given to the public through a variety of media, including advice from multiple health professionals, resulting in better understanding and uptake of the messages
- A greater focus by health and education agencies on supporting nutrition initiatives and developing nutritional policies and guidelines in schools and early childhood education centres, rehabilitation facilities, workplaces, marae, Pacific and migrant communities.

Example:

A nutritionist working with Pacific communities has used the Guidelines to inform her work with Pacific pregnant women, in particular to raise awareness around the higher risk of gestational diabetes amongst Pacific populations. Her programme provides information on the risks and causes of gestational diabetes and how it can be avoided as well as diagnosed, so that preventive information can be spread through Pacific women’s groups.

Reducing inequalities

None of the interview participants was able to easily identify any ways that the Guidelines might be used to reduce inequalities across New Zealand's various population groups, and many stated simply that this was not a reasonable expectation of the Guidelines, commenting that socioeconomic inequalities are caused by more pervasive political, social and economic factors, in particular the costs of food in relation to income level, that cannot be addressed in any significant way by the provision of dietary information. However it was seen as a potentially valuable goal for the Guidelines that could be developed further. Some 'top-of-the-head' suggestions for ways in which the Guidelines might help in this goal were ensuring that the Guidelines:

- Have a sufficient content focus on the ways in which diet and nutrition might contribute to inequalities (e.g. a section on the various factors contributing to poor nutrition for various population groups)
- Highlight food options that are relevant and accessible to disadvantaged families and populations (e.g. food types relevant to diverse cultures; low-cost breakfast ideas for low-income families who 'skip' breakfast; recommendations for nutrient enrichment of foods commonly eaten by socioeconomically disadvantaged groups – see also pp 25-26)
- Are highly accessible in both presentation and cost to the agencies with a primary focus on working with disadvantaged groups
- Are well promoted to agencies and relevant professionals working to reduce inequalities.

Example:

Te Hotu Manawa Māori has developed a range of culturally relevant presentations, using the evidence-based information in the Guidelines, that it takes to marae, hauora and other Māori groups and communities around the country. Personnel who deliver these presentations have drawn extensively on the Guidelines, and also customised the messages so that they are culturally relevant and acceptable to their Māori audiences.

"If I am going to be challenged in the community, I can say the messages are based on the Guidelines. They give me confidence in what I am saying to our people ... and hence the need for the Ministry to address any discrepancies."

"We pre-empt what some of the arguments are against healthy kai – mainly that they can't afford it – by doing a 'recce' of the area first, checking out stores and markets to see what is available, and then we can talk to whānau about those choices."

Monitoring impacts of the Guidelines

Several interview participants suggested that it would be valuable to have a formal process for monitoring the use of the Guidelines so that impacts and value could be assessed regularly. The simplest low-cost way to do this would be to set up a '5 minute' online survey for feedback on key aspects of the Guidelines and arrange prompts for people accessing the Guidelines to complete the survey. Those prompts could include a letter annually to all of the agencies to whom paper copies had been distributed in that year

inviting them to go online, and a ‘pop-up’ invitation when people access the Guidelines online. Because online survey technology allows for data tables to be produced at any time, data could be accessed for monitoring data annually or at greater or lesser periods, depending on the Ministry’s preference. Key aspects to be monitored might also be varied over time, again depending on what the Ministry most wanted to know.

Section C. Guidelines compilation and revision

6. Focus, scope and content

Summary

In general, survey respondents were reasonably satisfied with the relevance of the content of the Guidelines, seeing them as rightly focused on good nutrition for the New Zealand context. The main suggestions for improvement were a greater focus on food (versus nutrients), on realistic diet (versus ‘aspirational’), on enabling good nutrition and diet, on reaching as many audiences as possible (versus health practitioners primarily), and on the integration of activity guidelines with dietary guidelines. Ratings for the adequacy of the Guidelines were generally high accessibility, relevance to clients, relevance to health professions, comprehensiveness, evidence-based, easy of understanding, and referencing to information sources. Attributes that respondents rated lower were currency of the information, cultural relevance, and the practicality of the information. Nearly half of survey respondents identified perceived gaps or inaccuracies in the information, in particular around cultural relevance and information specific to particular dietary preferences and vulnerabilities, the financial inaccessibility of many healthy foods for some population groups, and a need for better alignment of the Guidelines with activity guidelines and those for obesity and weight management. The most common suggestions for improvements were for: more frequent updating of the Guidelines; more detailed and accurate information on portion sizes; improved hyperlinking to other relevant materials and resources; more ‘budget’ nutritional advice; a more robust evidence base, based on graded evidence; recommending foods that are environmentally sustainable; and a need for ‘mythbusting’ around good nutrition.

Focus of the Guidelines

In general, survey respondents were reasonably satisfied with the relevance of the content of the Guidelines, seeing them as rightly focused on good nutrition for the New Zealand context. However many participants, especially those interviewed, made suggestions for improving aspects of the Guidelines’ focus. The main suggestions were as follows:

Greater focus on food rather than nutrients

A common view was that the Guidelines currently appear to have a primary focus on nutrients and a secondary focus on food. This view occurred in part because the material around nutrients appears earlier in each document than the information around food, but also because of the proportion of the total content of each Guidelines document that was focused on nutrients. Participants commenting on this point felt that:

- To encourage reading for such a broad range of health practitioners, it would be more valuable to have the advisory information on food presented *first* in the Guidelines, and the information underlying that advice presented later, in part also because that information lends itself less well to visual formats
- The information on nutrients could be collated into one separate document to which other age-specific Guidelines all referred, thus avoiding unnecessary and costly duplication of material.

“They need to recognise that we eat food, not nutrients, and it’s a highly emotional and socially and culturally loaded behaviour.” Lecturer in nutrition

Reality versus ‘aspiration’

Many participants, both interviewees and survey respondents, commented that the focus in the current Guidelines is “*aspirational*” rather than realistic, in that they set out ideals that, however desirable, are likely to be unachievable to significant proportions of the New Zealand population. Their view was that adhering to the letter of the Guidelines was not realistic for health practitioners working with people on low or even “*middle*” incomes, and it would be preferable to have Guidelines that were more realistic than for individual practitioners to be deciding on what constituted an acceptable variation from the ideal. Participants variously believed that the Guidelines make a number of flawed assumptions, as follows, that:

- People are motivated to be healthy and to eat healthy food – that good health is a priority for the general public
- People understand the links between what they eat and their health status
- People all eat three meals a day, and believe that to be the best way to eat
- People believe that food is for health, rather than for other reasons such as fun or manaakitanga or consolation
- People like healthy foods and will want to eat them if they understand the links between diet and health
- Purchasing food is a priority for low-income families
- All parents know how to cook basic meals
- People are already reasonably healthy.

As examples, many participants noted, in relation to their clientele, that: the recommended portion sizes are typically not appropriate for clinically obese people; the foods recommended are often not easily accessible (e.g. to rural families with limited transport options); many families cannot afford three daily meals; many parents lack cooking skills of any kind; for many cultures, particularly new migrants managing cultural change, the cultural obligations around food and eating (e.g. eating what is placed in front of you) take priority over being healthy; and many people have little or no understanding of the links between poor diet and illness. As an example, one nutritionist described a Pacific client who carefully removed the fat from meat before cooking it, but then reduced the fat and used it for making pastry because she couldn’t afford to waste it.

The common suggestions were that the advisory information in the Guidelines have a stronger focus on what is realistic for the general population, and in particular for those groups who are seen as at risk nutritionally. This might mean, for example, that the Guidelines have a section on acceptable types or portions of various commonly enjoyed fast foods, “*treats*” for dieters, “*acceptable*” alcohol consumption for teens, and simple visual representations of a “*healthy plate*” that reflect what low-income families can actually afford. For example, Te Hotu Manawa provides Māori groups with a recipe for a healthy boil-up, in recognition that this tradition is central to many Māori family gatherings.

Focus on enabling good nutrition and diet

Many participants commented on the social, financial, geographic and emotional barriers to good diet and wanted to see more information on how to enable good diet. Common examples of barriers that health practitioners needed to understand and have strategies for were: loneliness amongst elders and people with mental health issues; fussy eating amongst infants, toddlers and teens; eating disorders; cultural pressures to eat; work/life balance

issues; and intergenerational lack of cooking and meal preparation skills. In similar vein, dental health professionals involved in the evaluation were keen to see information on dental advice around food types included in the Guidelines for all age groups. Some participants suggested that the Guidelines contain a section on ‘Applications’, outlining the various ways that the Guidelines can be used, and even perhaps including or hyperlinking to some examples (e.g. successful training programmes; policy development; the guidelines developed by Te Hotu Manawa Māori <http://www.tehotumanawa.org.nz/resources> and Diabetes NZ http://www.diabetes.org.nz/food_and_nutrition). Many participants wanted to see information on the lifestyle factors that detract from good nutrition, such as sleep deprivation and sedentary occupations.

“Academic” focus

Although participants acknowledged that it is entirely appropriate and essential for the Guidelines to be evidence-based, the layout and other aspects of presentation were seen by many as “dry” and not encouraging to readers unaccustomed to academic or research language. This focus could easily deter health practitioners without a tertiary qualification, or any very busy practitioner (and they all are), and prevent them from reading and understanding the evidence underlying the advisory information, or even from reading past the first sections to the more applied information later in the Guidelines. Many participants felt that the primary focus of the Guidelines needed to be on reaching as many audiences as possible so that “*we’re all singing from the same hymn sheet*”. Other suggestions for presentation are made later in this chapter.

“We want to be able to take the information and turn it into practical cooking lessons.” Māori nutrition advisor

Integration of activity guidelines with nutritional guidelines

A majority of those interviewed and many survey respondents commented that it made sense for dietary guidance to be integrated with advice for healthy activity to complement diet. Suggestions were either that guidelines on fitness and activity be incorporated in the Food and Nutrition Guidelines or that it be referenced and hyperlinked, to avoid adding to the length of the Guidelines. Several participants highlighted a need for the Guidelines to point out that a good diet will not keep people healthy if they’re not also active, some pointing to the recent research on sitting time and obesity.

Scope and content

Adequacy of the Guidelines content

Ratings for the adequacy of the Guidelines were generally high (average 2.6 or greater on a scale of 1=not very adequate to 3=mostly adequate) for accessibility, relevance to clients, relevance to health professions, comprehensiveness, evidence-based, easy of understanding, and referencing to information sources. Attributes that respondents rated lower (2.4-2.5) were currency of the information, cultural relevance, and the practicality of the information. The lack of currency of the information was identified as an issue across all health professions, and 44% of survey respondents identified perceived gaps or inaccuracies in the information (see below). Issues with cultural relevance were also identified across the professions, in particular by people in Māori and Pacific health and community and public health (see pp 25-26). Some participants also noted that ‘Asian’ is not an ethnic category, with Indian, Chinese/East Asian and Middle Eastern body types, food styles and medical susceptibilities being quite different in many ways.

Evaluation participants were asked to identify any gaps in the current Guidelines as well as to make suggestions for improvements generally. As people identified perceived gaps and made suggestions for content, an apparent underlying principle was that it is desirable for the Guidelines to be used not only by a broad range of health professionals, including community health workers and elder care workers, who may not have tertiary education in health, but also by professionals in other sectors, including teachers, dentists, early childhood education, so that the target audiences are receiving regular and consistent messages from all sectors.

Gaps in the Guidelines currently

Perceived gaps of various kinds were identified by the majority of interview participants and 44% of survey respondents, especially nutritionists, dietitians, academics/researchers and, interestingly, GPs. The gaps identified most commonly were as follows (in roughly this order):

- ***More up-to-date information*** – at least every 3-4 years to ensure the Guidelines reflect not only new knowledge but also population and food trends (e.g. packaged portions; new food types available; new knowledge about nutrient needs, saturated fat, causes of obesity, allergies, and mineral supplements⁶)
- Better ***specifics on portion sizes and numbers***, including: number of portions per day of various food groups, and of less healthy foods (e.g. sugars, salt, artificial sweeteners); pictures of a ‘portion’ for common foods, and of children’s versus adults’ portions; serving sizes for drinks
- More examples of healthy foods and nutritional requirements that are ***relevant to diverse cultures***, including cultural eating philosophies and patterns that affect diet (e.g. food as a gift; culture-specific food preferences and risks; Māori traditional wisdom around food and diet; Vitamin D requirements in darker skinned people); many Māori and Pacific evaluation participants voiced concern about the gaps in relevance of the Guidelines to Polynesian and other cultures and body types.

“The use of a flat Body Mass Index (BMI) for all ethnicities is controversial, and the use of the BMIs in the Guidelines legitimises that position.” Pacific nutritionist

“South Asian people are good at cooking but not very willing to change their diets. The perception is that they are thin, but they have high rates of diabetes... there’s not enough ethnically appropriate dietary advice. People eat what they are used to and much of the Guidelines point to Western diets.” PHO nutritionist

- ***Guidelines for “the frail elderly”***, focusing in particular on the impacts of common medical conditions on malnutrition risks
- Information on ***risks and diets for people with allergies*** (e.g. dairy, gluten) and others choosing organic foods (e.g. raw milks) and/or ***“restricted”*** diets, including vegetarians and vegans, given an apparent increase in people adopting these diets
- ***Better categorisation of healthy versus less healthy vegetables*** (e.g. starchy vegetables, vegetables cooked in fats)

⁶ Some examples given were the relationships revealed by recent research on: calcium supplements and heart disease; obesity and sleep deprivation; some cancers and lack of vitamin D)

- **Alignment of the Guidelines with obesity and weight management** guidelines and strategies (e.g. suitability of weight management products for teens and elders), and recommendations for inactive versus active people.

“Many parts of the Guidelines are very out-dates, like references to mince and potatoes. People are now eating a lot of different foods – pasta, tofu, hummus, chickpeas, pita bread, ricotta....” Public health nutritionist

“Practical advice is somewhat limited. Would also be good to give more details on how things happen in the real world, how the environment impacts our eating etc, this has a very real effect yet isn’t really addressed.” Survey respondent

“It’s not accurate to suggest a bread roll (often huge) is the same as a slice of bread when it comes to a serving size.” Survey respondent

“... a MUCH LARGER section on malnutrition and chronic diseases in older adults guidelines please. To cover respiratory disease, cancer, stroke, etc, impacts on nutrition and recommendations to prevent malnutrition.” Survey respondent

Other gaps each identified by a few respondents included: baby-led weaning; guidelines for schools around healthy fundraiser foods; a greater focus on early childhood education; impacts of food choices on dental health; managing fussy eating in children; and the needs of people with mental health issues.

One agency also felt that the Guidelines do not sufficiently analyse or interpret the information presented, in particular around the relevance of the research base for diverse cultural and ethnic groups.

Suggestions for improvements

Suggestions for improvements to content and focus were (in roughly this order):

- Much more frequent updating of information – Participants believed that:
 - ✧ All information in the Guidelines should be reviewed for accuracy every 3-4 years minimum
 - ✧ Advisory information might need to be reviewed more frequently
 - ✧ Information with a known short half-life should be reviewed every 2-3 years and included in a ‘register’ of information requiring frequent review
- More **information on portion sizes**, food choices and food preparation, making it relevant to contemporary food and meal types (see also p 25)
- Improved coverage of **nutrition for diverse ethnic and cultural groups** in New Zealand, including Māori, Pacific nations and new settler ethnicities, in particular recognising the cultural norms around eating and particular morphological vulnerabilities of those cultures
- Frequent use in the Guidelines of **hyperlinks to other relevant materials**, including:
 - ✧ More detailed information on particular topics – this was seen as a way of potentially reducing the length of the current Guidelines to make them more accessible to some people (e.g. those whose first language is not English)
 - ✧ Materials referenced in the Guidelines
 - ✧ Cross-referencing of material across the various Guidelines documents
 - ✧ Areas of related health information (e.g. the Nutrition Survey findings; specialist

- information)
- ✧ Related health campaigns, including regional campaigns
- ✧ Resources for the public (e.g. pamphlets, menus, fitness opportunities for the public [e.g. free public recreation facilities], weight loss information)
- ✧ Relevant YouTube clips and other video resources
- ✧ Dietary guidelines in other countries
- ✧ Other relevant information (e.g. crop and food research; meal ideas; recipes; healthier fast food options)
- Better ***alignment of the Guidelines to other relevant health campaigns***, such as those for weight loss, quit smoking, dental health, breastfeeding, cancer prevention, alcohol reduction, kitchen gardens.
- ***More ‘budget’ nutritional advice***, which was seen as essential not only in the current recession environment but in general, given the established links between poverty and poor diet and the reality of poverty for large numbers of New Zealanders, and in particular those in the ‘high risk’ groups.
- ***Graded evidence base***. Many of the survey respondents and interview participants commented that the evidence standards for the Guidelines were not sufficiently documented, so that readers were unclear about the reliability of the information. Some people with acknowledged expertise in nutrition commented that the evidence used either needs to apply a high evidence grade throughout the Guidelines or the evidence standard needs to be identified for all information pitched as advice, recommendations or policy.
- A focus on ***recommending foods that are environmentally sustainable*** (e.g. avoid eating fish more than once a fortnight; information about threatened fish species; recommendations for eating locally produced foods versus imported; suggestions for easy home gardening)
- ***Electronic updating of information*** that has a short half-life (e.g. migrant/new settler dietary needs and advice; links to current campaigns)

Many participants also highlighted the need for ‘***mythbusting***’ in the Guidelines, pointing to what they saw as common myths around good nutrition, often promoted by manufacturers’ advertising, that were confusing to the public. Common examples were:

- Margarine (like Flora) reduces cholesterol
- Drink Milo for energy
- Eat Nutrigrain for strength
- You need large quantities of vitamin B12
- Drink energy drinks like Mizone (although they have high amounts of caffeine)
- Take glucosamine/chondroitin for your joints
- Tea is better for you than coffee; brown sugar and honey are healthier than white sugar
- White chocolate and energy chocolate are ‘healthier’ than dairy milk
- Misleading information on a plethora of weight-loss and ‘detox’ diets.

“We don’t have the time to sift through everything, it’s too confusing... we need the Ministry to provide some clarity and guidelines about some of the new information.”
General practitioner

7. Presentation

Summary

Ratings for satisfaction with the presentation of the Guidelines were reasonably high for user-friendly language, logical layout, information easy to find, the index adequate, and table of contents easy to follow. However people who had been involved in the development and redevelopment of the Guidelines believed that the current layout is not optimally user-friendly. Other attributes that survey respondents found less satisfactory were sufficient use of visual formats and culturally relevant language. Dissatisfaction around the use of culturally relevant language and examples was common across most professional categories and especially amongst people in Māori and Pacific health, maternity services, and primary and secondary education. The common theme amongst participants' suggestions for change to the Guidelines was around making the content more accessible to the full range of health practitioners, to encourage uptake of more of the information in the Guidelines and facilitate easy use of the material. The main suggestions for improvements were: greater use of visual formats rather than narrative text; greater use of formatting to highlight information; more 'modern' presentation; more user-friendly, contemporary, "personal" language; increased use of language, references, information and examples relevant to Māori and cultures other than Pākehā and European cultures; pictures of portion sizes; avoidance of vague terms that remain open to wide interpretation; and having the Guidelines available in Word as well as PDFs, so that information can be readily copied.

Presentation and layout of the Guidelines

Ratings for satisfaction with the presentation of the Guidelines were reasonably high (average 3.4-3.5 on a scale where 3=moderately satisfactory and 4=completely satisfactory) for user-friendly language, logical layout, information easy to find, the index adequate, and table of contents easy to follow. Nonetheless there were large numbers of people, in particular those in Māori and Pacific health, maternity services and the education sector, who found the layout less than satisfactory. Moreover, people who had been involved in the development and redevelopment of the Guidelines, and/or had seen the recently developed Australian and US dietary guidelines, believed that the current layout for the Guidelines is not very user-friendly, and their views were supported by the comments of many survey respondents who found the presentation "off-putting".

"It's a lot of pretty dense text up-front, all focused on nutrients rather than food. All of that material needs to be at the back, not the front... Most people using the Guidelines want to find practical advice first, they don't have time to read all of the evidence."

Dietitian

Other attributes that survey respondents found less satisfactory (3.2 average rating) were sufficient use of visual formats and culturally relevant language. Respondents' comments supported these ratings. Dissatisfaction around the use of culturally relevant language and examples was common across most professional categories, but in particular again amongst people in Māori and Pacific health, maternity services, and primary and secondary education.

Suggestions for improvements

The common theme amongst participants' suggestions for change to the Guidelines was around making the content more accessible to the full range of health practitioners, to firstly encourage uptake of more of the information in the Guidelines and secondly facilitate easy use of the material in them.

Specific suggestions for improvements were made by nearly a quarter of survey respondents, in particular people who had worked in health for more than five years. Some of the suggestions for improvements indicated that some respondents believed that the Guidelines are intended for use by people other than health professionals and may not have been aware of the public resources. Nonetheless, similar suggestions were made by practitioners who were well aware of those resources but still felt that the Guidelines were a bit too “*academic*” in their appearance to be enticing reading.

The most common suggestions for improvements to presentation were (in approximately this order):

- Greater use of **visual formats** rather than narrative text were requested by respondents across all professional categories – suggestions included: tables; graphs; charts; more colour images for exemplars of health food (e.g. examples of a ‘healthy plate’). Many participants referred to the new Australian and the US dietary guidelines as examples of more user-friendly visual presentation.
- Greater use of **formatting to highlight information**; suggestions were: use of bold type or contrasting fonts to emphasize words; variation of fonts to indicate heading levels; more colour and shading to code information (e.g. headings; sections of information); greater use of subheadings for better identification of information; use of colours that convert effectively in greyscale (for lower cost printing)
- More **‘modern’ presentation** – more up-to-date images (e.g. activities, dress and hair styles, foods introduced in recent years)
- More **user-friendly, contemporary, “personal” language** that addresses the reader – less “*clinical*” terminology
- Increased use of **language, references, information and examples relevant to Māori and cultures** other than Pākehā and European cultures. Many respondents felt that the Guidelines currently appear oriented to Pākehā and lack apparent relevance to Polynesian and other cultures. Specific suggestions included the following:
 - ✧ More use of commonly used terms in te reo and other languages used commonly in New Zealand
 - ✧ More images relevant to Māori and other cultures (e.g. sports, family activities, faces)
- **Pictures of portion sizes**, in preference to weights or other “*vague*” measures (e.g. ‘cup’ fractions)
- **Printable resource materials** for use with the public included as appendices in the Guidelines
- **Avoidance of vague terms** that remain open to wide interpretation (e.g. “*some*”, “*limit*”, “*plenty*”).

“The Australian guidelines use phrases like “enjoy” more servings of fruit, not “eat” more fruit – the psychology of the language makes all the difference to how the information is received.” Health academic

“[The Guidelines] carry no real weight, because a lot of the words are quite difficult to follow – like what does ‘limit’ mean to our people [Māori whānau]? So you can’t go to families and just say ‘follow the Guidelines and everything will be hunky dory’.”
Māori nutritionist

Other suggestions made each by more than 3% of total evaluation participants⁷ were (in roughly this order):

- Having the Guidelines available in Word as well as PDFs, so that information can be readily copied and pasted
- Having running headers indicating which section the information is in
- A more comprehensive index
- More interactive formats (e.g. short quizzes, a ‘scavenger hunt’ for information)
- Having the Guidelines, or at least the public resources, available in languages commonly used in New Zealand, especially those of target populations (e.g. Tongan, Samoan, Cantonese)
- Having key information summarised at the front of each Guideline
- A section at the front of the Guidelines setting out (1) what’s not covered and (2) the easiest way to navigate the documents
- A search tool for better navigability of the Guidelines by key words
- Ringbinder rather than less robust glue-bound paper copy, so that replacement with updated information is easier and cheaper.

⁷ Including survey respondents, so these were large numbers of responses.

8. Distribution and accessibility

Summary

Knowledge of how to access the Guidelines amongst those who were aware of them was high for dietitians, nutritionists, midwives and lactation consultants, nurses and academics/researchers, but relatively poor for GPs, health promoters, health educators/teachers and community health workers. Paper copy was the usual access medium of 63% and electronic used by 53%, with 19% using both media. However when asked what their preferred medium was, only 40% said paper. Electronic access was a preferred medium of 60%, with 20% wanting the Guidelines available to them in both paper and electronic form. Where people wanted paper copy to continue to be made available, the reasons boiled down to cost or not having access to a quality printer. The main issue identified with distribution was the cost of printing and despatching paper copies. Suggestions for improvement focused on; supporting people to use electronic documents; providing the Guidelines in formats that can be printed cheaply; determining ways to make paper copy either unnecessary or less expensive to produce; diversifying formats and media for greater accessibility; a dedicated website; use of the social media for distribution and promotion; and alignment with a promotions strategy for the Guidelines.

Distribution

Currently the Guidelines are distributed in two main ways – via the Ministry of Health website, in downloadable PDFs as six separate documents, and in paper copy. Paper copies are sent to selected key stakeholders who are known to use the Guidelines extensively (e.g. DHBs, professional associations for health practitioners of various types, health advocacy organisations, some other provider agencies). In addition, the website invites people to request paper copies if they wish; it was unclear whether there were any criteria as to who could request copies of the Guidelines, how many copies could be requested, or whether there is a finite budget for paper copies and their distribution.

Distribution for the public consultation when each Guidelines document is being reviewed and revised is also both electronic and in paper copy (see Chapter 11).

Issues with distribution

The main issue identified with distribution was the cost of printing and despatching paper copies. The Guidelines documents are between 140 and 260 pages each, and even if they are double-sided, printing and binding are expensive. If they contained more colour and visual formats than at present, they would inevitably be even more costly. For this reason, many survey respondents requested that paper copies continue to be made available free, because they believed their organisations would not be able to afford to print out copies, especially if several staff wanted their own copy. However the costs remain a major expense for the Ministry in an era of increasing use of online distribution.

Accessibility

Knowledge of how to access the Guidelines amongst those who were aware of them was high (around 80-90%) for dietitians, nutritionists, midwives and lactation consultants, nurses and academics/researchers. Nonetheless 32% of GPs, 29% of health promoters, 23% of health educators/teachers, and 40% of community health workers who were aware of the

Guidelines did not know how to access them or were 'not sure'. Only a third of pharmacists knew how to access the Guidelines.

Access medium

Patterns for ways in which survey respondents accessed the Guidelines were as follows:

- Paper copy was the usual access medium of 63% and electronic used by 53%, with 19% using both media.
- Those most likely to access the Guidelines electronically were pharmacists, tertiary educators, GPs, people in Pacific health and Asians. The factor common among at least the first three of these groups is that they use a computer as a frequent everyday aspect of their work.
- In contrast, those who typically used paper copy were dietitians, nutritionists, nurses and people working in community health and public health, who are more often working in either community or hospital settings where there may be less easy access to a computer. Anecdotally, many younger people in these jobs amongst those interviewed preferred electronic access, suggesting that there may be a trend towards electronic access, as there is generally towards greater use of electronic means for accessing information of all kinds. People the least likely to use electronic access were Pākehā and those who had been working in health for either more than 10 years or less than one year. Practitioners most likely to prefer paper copy were midwives (70%) and nurses (63%). Many survey and interview respondents identified their preference for hard copy as a function of older age or generation – *“being older, it’s what I’m used to”,* or *“I can’t be bothered with endless scrolling...”*.
- However when asked what their preferred medium was, only 40% said paper. Electronic access was the preferred medium of 60%, with 20% wanting the Guidelines available to them in both paper and electronic form. Where electronic access was preferred by interview participants, it was for one or more of the following reasons: because they wanted the ability to forward the material to colleagues; to copy and paste parts of it into other documents; because it was easy to carry with them on a laptop for quick access; or because that was their preferred medium for accessing information generally.
- Reasons for wanting access in both media were that people wanted the advantages of having electronic copy for the reasons just given, but also wanted paper copy because either they found it easier to read and negotiate a book than a screen and/or they wanted to avoid the costs of printing.
- Where people wanted paper copy to continue to be made available, the reasons boiled down to cost or not having access to a quality printer. Survey respondents commented that many service agencies would find it too expensive to print copies for all staff or even all departments.

In general participants thought that accessibility for utility could be improved by enhancing content and focus, presentation and distribution (see below, and Chapters 6-7).

Suggestions for improvements

Distribution strategy

Several participants suggested that a distribution strategy be developed as a priority task, defining for various Guidelines components the goals of distribution, priority and secondary audiences, setting distribution targets, determining appropriate and cost-effective media, identifying agencies that can assist with distribution (e.g. health providers, education providers, professional associations), and exploring a range of ways to reach hard-to-reach

audiences.

Electronic or paper?

It is apparent that there is a trend towards increasing use of electronic access, and more than 60% of survey participants were already accessing the Guidelines online. Given the costs of paper distribution, it makes sense to reduce the paper medium if possible so that funds can be spent more effectively. Some solutions to the high costs of paper copies, while still retaining a paper option, may be to:

- Educate people in how to use online documents easily
- Include short guidelines in the front of the documents on how to negotiate them easily in electronic form
- Presentation of the Guidelines in ways that make particular areas of information easier to access (e.g. improved indexing; hyperlinking)
- Provide the Guidelines in formats that can be printed cheaply, that is, using colour formats that are easily visible in greyscale
- Have increased use of visual formats for commonly used information in downloadable PDF charts hyperlinked to the Guidelines
- Continue to make paper copies available either to key agencies (e.g. DHBs, PHOs, libraries) or on a subsidised rather than free basis
- Establish a set of eligibility criteria for free or low-cost paper copies, based on criteria such as likely frequency of usage (e.g. dietitians and nutritionists), income (e.g. free for NGOs or agencies with an annual income of less than \$500,000), or potential value of using the Guidelines (e.g. free for schools and hauora)
- Advertise on the website where paper copies can be located and/or borrowed (e.g. libraries of DHBs, professional associations and tertiary education institutions).

Diversifying formats and media

Many evaluation participants recommended developing the material in the Guidelines into diverse formats to meet the needs of different audiences and varying uses. Particular suggestions were:

- Compiling the information in a range of formats for diverse purposes and audiences, so that they are more accessible across professions, cultures and different learning styles, for example:
 - ✧ 1-2 page information summaries for key areas of information that can be printed out for handy reference (e.g. laminated by users for carrying around to clients)
 - ✧ Charts and posters available to print out in varying sizes (e.g. for pharmacies, clinics, schools)
 - ✧ Recipe books (e.g. for \$10 family meals) cheaply produced for purchase
 - ✧ Resource kits (e.g. similar to those provided in the Cardiac Rehabilitation Guidelines⁸)
 - ✧ DVDs – either locally made or overseas-produced was seen as valuable
 - ✧ Twitter updates, profiling the latest research in brief

⁸ See <http://www.google.co.nz/search?q=Cardiac%20Rehabilitation%20Guidelines%20nz&ie=utf-8&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a&source=hp&channel=np>

Dedicated website

Many evaluation participants suggested that the Guidelines needed to be more easily accessible online. The three main suggestions for achieving this were:

- Making it easier for people to locate the Guidelines on the Ministry's website (e.g. a 'flag' on the home page)
- Having the Guidelines on the Health Improvement and Innovation Resource Centre (HIIRC) website <http://www.hiirc.org.nz/> ; however this site has been set up for health practitioners and may be less user-friendly for others
- Setting up a dedicated website for the Guidelines, as has been done elsewhere. The Department of Health and Aging in Australia is developing, for the first time, a website dedicated solely to the guidelines, rather than having them accessed through the Department's main website. The US and Canada have both adopted this approach, to make their guidelines more immediately accessible for online search.

"In pharmacy there is often a customer waiting and you have 1 minute, so have a VIEW GUIDELINES button at the top of the page... not some annoying and supposedly intuitive process of clicking and clicking and clicking and maybe finally being able to view a PDF." Pharmacist

Social media

Use of social media tools – Twitter and Facebook – were suggested by several evaluation participants to promote the Guidelines. The Department of Health and Aging in Australia is taking advantage of these tools, and HIIRC already uses Twitter to promote the information and resources available on that website <http://twitter.com/#!/HIIRC/status/27297826935> .

Alignment with a promotions strategy

See the following chapter for participants' suggestions for aligning distribution with promotion.

9. Awareness and promotion

Summary

Awareness of the Guidelines varied across professions and sectors, based partly on the extent to which nutritional advice was seen as a core part of each profession's work. However awareness also varied within professions, depending on particular roles, the philosophy of the agency, or even personal views of the importance of nutrition versus other aspects of well-being. Many survey respondents believed the Guidelines are not sufficiently promoted, either within the health professions or across other sectors. The main suggestion for improvement was to develop a comprehensive promotions strategy for the Guidelines, identifying key target audiences, determining the most effective strategies and techniques to promote the Guidelines to each, and then exploring 'smart' ways to use the various media available to reach each of those audiences cost-effectively, including both 'push' and 'pull' strategies.

Awareness of the Guidelines

Awareness of the Guidelines varied across professions and sectors. Of total survey respondents, 72% had been aware of the Guidelines prior to undertaking the survey, and awareness was high (80-95%) across most professional groups surveyed. Most of those who had not been aware of the Guidelines previously were pharmacists and GPs⁹. However 24% of nurses and 20% of community health workers who responded to the survey had not encountered the Guidelines previously.

Many evaluation participants assumed the variation in awareness was based on the extent to which nutritional advice was seen as a *core* part of each profession's work. However views about the latter also varied across individual practitioners within some professions, depending on their particular role or job description, the philosophy of the agency in which they were working, or even their personal views of the importance of nutrition versus other aspects of well-being. (For example, some evaluation participants working with economically disadvantaged families felt that helping families to be safe was more important than encouraging them to adopt a good diet, especially when many healthy foods were not affordable to those families.) These gaps in awareness suggest that improved promotion is desirable.

It was apparent from the comments of many survey respondents who had not previously been aware of the Guidelines that they believed this was a function of insufficient promotion within their professions. Some respondents who commented in this way had clicked the hyperlink to the Guidelines in the invitation to take part in the survey and been impressed at the value of the information available in the Guidelines.

Promotion

Promotion of the Guidelines at present is mainly through the distribution process, together with occasional promotion by Ministry personnel at conferences and other events involving health practitioners. There is currently no documented promotions strategy as such for the Guidelines. The Ministry sends a copy of 'draft for consultation' and updated final version

⁹ Since the only doctors invited into the survey were general practitioners, we have assumed that those identifying themselves are likely to be GPs.

documents to a significant number (200+) of stakeholder groups and individuals, which acts as a form of promotion of the Guidelines.

Many survey and interview respondents suggested that the Guidelines need to be promoted much more proactively, both within the health professions and for wider usage across other sectors. None of the evaluation participants (other than current or previous project personnel) was aware of any active promotion of the Guidelines, and several commented that, on that basis alone, a need for promotion was indicated. In other countries comprehensive promotional strategies have been developed that have focused on multisectoral distribution and promotion¹⁰. In the United Kingdom (UK), United States (US) and Australia, the trend is towards targeting all social services and education sectors in promoting their dietary guidelines. (See the literature review provided separately for coverage of promotional strategies used overseas.)

Suggestions for improvements

If it is a goal of the Guidelines to promote and support healthy diets across the population at large, then evaluation participants believed that promotion needs to be far reaching and encompass the education sector, private sector, food industry and all cultural communities. Several participants felt that the most important use of the Guidelines budget is on promotion, to increase the number of people using them so that the ultimate target audiences receive the messages more often and from a wider range of influences.

Promotions strategy

Several interview participants believed that it was essential to develop a comprehensive promotions strategy for the Guidelines, identifying key target audiences, determining the most effective strategies and techniques to promote the Guidelines to each, and then exploring 'smart' ways to use the various media available to reach each of those audiences cost-effectively, including both 'push' and 'pull' strategies (e.g. focusing on ways that the Guidelines can be used to enhance professionals' job satisfaction and/or improve client outcomes with least effort or intervention).

Specific suggestions

Promotion suggestions from evaluation participants included the following:

- Working with the professional associations to promote uptake and use of the Guidelines (e.g. Continuing Medical Education (CME) credits for online tests based on the Guidelines)
- Attendance by Ministry personnel at the forums of professional associations, rūnanga, Pacific churches and agencies, migrant services agencies, and other forums and events
- Trade displays (unstaffed) at conferences and seminars
- Promotion through the newsletters of professional bodies, regional agencies, other Ministries and Departments, community newspapers
- Encouraging other agencies to include promotional material and hyperlinks to the Guidelines on their websites (e.g. by providing the text)

¹⁰ For example, in Canada the implementation plan included five strategies for action: (i) development of food and nutrition policies, (ii) collaboration and coordination among partners, (iii) multisectoral promotion, (iv) community-based nutrition initiatives, (v) research and evaluation.

- Collaboration with public campaigns (e.g. the ‘Meat-free Monday’ campaign in the US and UK - <http://www.meatfreemondays.com/index.cfm>)
- Distribution to workplaces and industry bodies for forward distribution to employers and employees, and promotional activity in selected workplaces with employees in populations at risk of obesity-related conditions
- Funding support for cooking classes, and/or links to online and You Tube budget cooking resources (e.g. <http://www.youtube.com/watch?v=ASEu4jbygXw>; <http://www.foodinaminute.co.nz/>).

10. Compilation and review of the Guidelines

Summary

A majority of survey respondents were either not familiar with the process for reviewing the Guidelines (58%) or unsure if they knew about it (6%). Of those who were aware of the Guidelines review process, 41% overall had made a submission at some time and three quarters of those had found that process useful. The review process was widely seen as too long in its current form, resulting in outdated information in the Guidelines. Many evaluation participants believed that too much of the available budget was being spent on the review process currently, rather than on the contents, presentation and promotion of the Guidelines. The most common barriers to participating in the review process were that people were not aware of a review occurring, they did not have enough time to make a written submission, and/or the agency could not afford to pay someone to make a well considered, evidence-based submission. Many respondents felt it was unnecessary for them to submit when their professional body was doing so. Survey respondents were almost equally divided as to whether a public consultation process was necessary – 41% ‘yes’ and 38% ‘no’, with a further 21% ‘not sure’. A majority of interview participants believed that a full public consultation was not necessary, especially balanced against the time and costs involved, as long as it were replaced by a robust and representative stakeholder consultation. Many interview participants saw the current management and governance structures as lacking effectiveness, in particular that (1) the project management role is too large, too complex, has too many responsibilities, is susceptible to personal bias and isolated, and that (2) there is insufficient structured governance for the project. Specific suggestions were made for improving the Guidelines review processes, including governance and management.

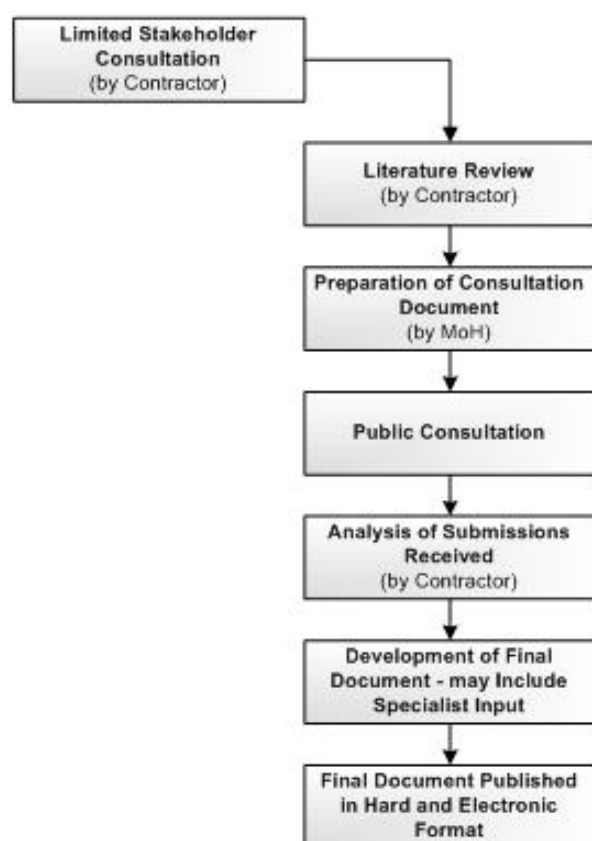
The Guidelines review and revision process

Currently the Guidelines are revised through a ‘rolling review’ process, with each age-specific Guidelines being revised approximately once every 10 years, due to the time required and available budget. The review process is summarised in **Figure 1** below.

The public consultation process has been included with each revision as a demonstration of inclusiveness by the Ministry and to ensure the broadest possible input into the revisions. Distribution of drafts for the public consultation is both electronic and in paper copy. Paper copies are sent to selected key stakeholders whose input is thought to be essential with an invitation to make a submission within a specified time frame. The consultation is also announced on the Ministry’s website and through other forums (e.g. agencies’ newsletters).

Evaluation participants were asked in interviews and the survey for their views of the current process for revising the Guidelines. And whether they had ever taken part by writing a submission.

Figure 1: Guidelines review process



Awareness of the review process

Only 36% of survey respondents had been aware of the Guidelines review process. A majority of survey respondents were either not familiar with the process for reviewing the Guidelines (58%) or unsure if they knew about it (6%), including 65% of nurses, 66% of those working in community health, 77% of health promoters, 83% of the midwives and 90% of community health workers, pharmacists and those working in Māori health. Even amongst dietitians 35% were unfamiliar with the process, as were 52% of nutritionists and 45% of health educators.

Public consultation participation

Of those who were aware of the Guidelines review process, 41% overall had made a submission at some time in that process. Submissions were more likely to have been made by dietitians (54% of those aware of the process), academics/researchers (50%), nutritionists (45%) and by people working in public health (61%), Pacific health (50%) and maternity services (50%), than by people in other sectors.

Where respondents had made a submission, three quarters (76%) thought that that process had been useful for them. In particular dietitians, nurses, people working in public health and hospitals, and those working in Māori and Pacific health had found the submission process useful. Interview participants commented that they had found the submission process useful because it helped them as practitioners, or the groups or agencies they represented, to clarify their views, and also because frequently the information was picked up and incorporated into the revised Guidelines, improving them.

Issues with the Guidelines review process

Length of the review process

The main criticism of the review process was that it took too long in its current form, thus delaying the timely updating of information and resulting in outdated information in the Guidelines documents. This was seen as a major fault, given health practitioners' reliance on the Guidelines being current.

"A lot of nutritional information has a short half-life, because of the research happening all the time plus changes in health trends... We rely on the Guidelines being up-to-date, and if they're not then we're either giving inaccurate messages to people or we're all saying different things because some people are more up-to-date in their fields than others." Professional association

Literature review and peer review processes

Participants identified the following problems with the current writing processes:

- The current process has a contracted academic undertaking a literature review and then a Ministry person converting that material into Guidelines in a format suitable to the audiences, resulting in a long time being required for the writing and some duplication of activity, as well as the costs involved in a dual writing process.
- There are two stages of peer review, one for the initial draft and a second for the final draft, again duplicating activity and costs, and adding to the time frame.
- The scope of the literature review is huge, and arguably too great for one person to do well, given the inevitable limitations on any one person's area/s of subject expertise.
- In Guidelines documents revised in the past few years, the Ministry has contracted an organisation based on the organisation's claim that it has a 'team' of people to undertake the literature review, who can provide expertise in a number of areas (for example, specific cultural groups; scientific reviewing skill; practical application of evidence). The Ministry's experience, however, has been that ultimately the contracting organisation delegates to one person to do the work, with no or minimal input from others.
- It was unclear to key stakeholders whether appropriate people were being involved in the peer review stages to ensure that the content was sufficiently representative and useful for the target audiences.
- It is unclear whether the revision process applies a robust system for grading the material included as 'evidence'.

Budget limitations and allocations

Many evaluation participants believed that too much of the available budget was being spent on the review process currently, rather than on the contents, presentation and promotion of the Guidelines. Three interview participants commented that the budget available for contracting writers is not sufficient to attract people with the necessary skills at a high level, noting that the fee did not cover the number of hours required to do the work to a high calibre.

“Who’d want to do it? As an academic you can’t count it as research for the PBRF¹¹, and the fee doesn’t cover the work involved – it’s peanuts and monkeys....” Health academic

Barriers to taking part in the review process

A majority of survey respondents reported no barriers to taking part in the review process. Where evaluation participants did report barriers, the most common were that:

- People were not aware of a review occurring
- They did not have enough time to make a written submission, and the requirement was for a submission in writing, rather than being able to attend a forum; the time barrier was generally a combination of heavy workloads, other priorities and the short time frame allowed by the Ministry for submissions, with participants indicating their perception that submissions needed to be comprehensive and evidence-based
- The agency could not afford to pay someone for the considerable time seen as necessary to make a well considered, evidence-based submission.

“You can’t just cobble something together – it takes days to put together a decent credible submission, even for someone who’s an expert, and they won’t take notice of anything that isn’t backed up....” Nutritionist

Many respondents commented that they did not think it was necessary for them to submit, because their professional body was making a submission. Three evaluation participants noted that having to make submissions in English is a significant barrier for Pacific and other new settler groups for whom English is a second or third language.

However many survey respondents commented that it was vital that the review process include important stakeholders, especially the professional associations for dietitians and nutritionists, those whose profession it is to keep up-to-date with developing knowledge in the area, such as academic/practitioners, and representatives of the groups particularly targeted by the Guidelines. Many also suggested that the Ministry consider a forum or “focus group” process where interested people could provide their input orally, rather than having to write comprehensively. It may be that an email ‘hotline’ would serve this purpose, as was used in the current review of the Australian dietary guidelines.

Is public consultation necessary?

Survey respondents were almost equally divided as to whether a public consultation process was necessary – 41% ‘yes’ and 38% ‘no’, with a further 21% ‘not sure’. Those who believed it was necessary were more often people working in Pacific health (71%), Māori health (65%), health promoters (57%) and community health workers (55%), and their reasons for believing public consultation was necessary were largely focused on either:

- Ensuring that the needs, views and preferences of diverse communities (cultural and other communities of interest) were taken into account so that the Guidelines reflected that diversity and were thus relevant and useful to all groups
- Ensuring that the Guidelines were realistic and practical by reflecting the needs, views and preferences of the ‘high risk’ groups at which the Guidelines are significantly

¹¹ Performance-Based Research Funding.

targeted; that is, the Guidelines needed to have a ‘bottom-up’ aspect in order to have utility.

A majority of interview participants believed that a full public consultation was not necessary, especially balanced against the time that it requires and the costs involved, as long as it were replaced by a robust and representative stakeholder consultation. Several people argued that public consultation was entirely unnecessary as long as the evidence base sets a criterion for graded evidence, the materials are being reviewed and revised by subject experts, and there is appropriate representation within both the peer review process and the governance group (see below).

Management and governance structures

There was a high level of consensus amongst participants who had been involved in the compilation and review of the Guidelines over the past several years that the current management and governance structures are not effective. The people who have undertaken the role typically experienced it as onerous and not very rewarding or satisfying. The main concerns with the current structures and systems were that:

- The project management role is too large, too complex, has too many responsibilities, is susceptible to personal bias while it is undertaken by only one person, and “*thankless*”; it was also seen as isolated, and the common perception was that it needs at least two people involved in it for the role to be undertaken safely
- There is insufficient structured governance for the project, and it is not sufficiently representative of the sectors targeted by the Guidelines.

Improvements to the Guidelines review process

All of the interview participants and around 13% of survey respondents made suggestions for ways in which the Guidelines review process could be improved. The majority of these suggestions centred on improving the frequency with which the Guidelines are reviewed and updated, and making management and governance more effective.

Structure of the review process

Specific suggestions for ways in which the review process might be better structured were as follows:

- Ensuring that each Guidelines document is ***updated at least once every 3-4 years***, to ensure currency of the information. The common perception was that, if the Guidelines were reviewed more frequently, then any outstanding gaps or issues could be addressed reasonably quickly, balancing the need for the Guidelines to be completely accurate at all times.
- Replacing the lengthy public consultation process with a more focused review by a carefully composed ***Review Advisory Group*** with broad representation based on an agreed set of Guidelines purposes, outcomes goals and audiences. Generally evaluation participants believed that such a process would be sufficient provided that all of the relevant professional associations and advocacy or interest groups were represented in that process, and the groups’ selection process was transparent and inclusive.
- ***Collaboration with the various relevant professional associations*** to ensure that their members are informed about and have opportunities to feed into reviews through those associations.

More specific suggestions were made based on a proposal for a significant restructuring of the Guidelines which is set out in the following chapter.

Finally, some participants recommended that a specialist project management consultant be employed to assist the Ministry in the transition to a changed review structure and project management structure (see below).

Literature review and peer review processes

- Ensuring sufficient input into the review process from Māori with relevant expertise, where that was defined as expertise in not only health information but also presentation and promotion
- Ensuring that there is a transparent process for balancing the diverse input of academics and strong lobby groups with those of information accuracy and representativeness
- A process for examining both sources of information ‘bias’ and relevance to New Zealand populations
- Closer collaboration with Dietitians New Zealand to make best use of their expertise
- Providing a clear and comprehensive brief to the authors commissioned to compile drafts, setting out the specifications and describing the outputs more clearly than hitherto (e.g. tasks, scope, boundaries), to ensure that the review process is systematic
- Making clear what evidence grading or standards are being applied
- Making the literature review credit-worthy for the universities’ Performance-Based Research Fund (PBRF), so that academics are more likely to make the time to engage.

“It should be left to the experts, that’s their job. The trick is to make sure that they [Ministry] include enough of the right people to make sure the bases are covered and the various health sectors are satisfied that their interests are represented in there.”
Dietitian

“There needs to be input from the people that the Guidelines are aimed at... There’s no point in giving advice to school teachers and even dietitians that the patients are just going to say, ‘well, we can’t afford those foods’ or ‘my kids won’t eat it’.”
Nutritionist

Is public consultation necessary?

If the Ministry were to continue the public consultation process, then suggestions were that:

- The process be better communicated through professional associations and other forums
- The submissions be structured around a few questions only, to make them quicker to analyse
- An email hotline be considered for submissions, with advice to the sector that submissions do not have to be lengthy
- There be greater clarity around the capacity of the Ministry to include all material included in submissions, so as to manage the expectations of people making submissions
- Making the submission process credit-worthy for the universities’ Performance-Based Research Fund (PBRF), so that academics are more likely to make the time to engage.

Management and governance structures

The collated suggestions of interview participants were for the following management and governance structures:

- Establishment of a Steering Group to provide governance for Guidelines development. The Steering Group would be carefully composed to represent *all* key stakeholders, have a clear terms of reference, meet monthly initially and then 4-6 times a year (potentially by teleconference), and guide all of the development of the Guidelines. One participant recommended the Steering Group for the Ministry's elder activity guidelines as a good model.
- Restructuring of the project management role into two positions – one having responsibility for 'technical' aspects of the Guidelines development, the other having responsibility for overall project management. Interview participants recommended a comprehensive analysis of all of the tasks currently undertaken by the project manager, reviewing the appropriateness of those tasks and identifying the skills sets needed, and then redefining the role into two. These two people might well have other jobs in addition to the Guidelines role, or might work part-time in the role.
- The PRINCE2 project management system was suggested by two participants as providing a model for establishing a new project management structure.

Section D. Conclusions and future options

11. Cost-effectiveness

Summary

Cost-effectiveness of the Guidelines is difficult to assess without comprehensive budget and benchmarking information. Confidential information on ballpark costs was obtained from only one overseas agency and has been provided to the Ministry separately. Evaluation participants were not able to identify another set of guidelines developed in New Zealand that they saw as similar in scope to the Food and Nutrition Guidelines for benchmarking purposes. However there was a widespread perception that there were some high-cost activities in the development of the Guidelines that might be undertaken at a lower cost, thus freeing up funds for other features. Costly activities that might be obviated were the extensive paper distribution of the draft and complete Guidelines, the double peer review process, and undertaking a comprehensive evidence review, versus purchasing that information from overseas or co-funding through a collaboration with an overseas agency. Evaluation participants identified viable alternatives to those processes and several areas where funds might be spent to greater effect.

Perceptions of cost-effectiveness of the Guidelines

The Ministry has not undertaken a detailed analysis of the costs of the Guidelines including both external and internal costs (e.g. salaries and costs absorbed in general operational budgets).

Interview participants were asked for their views of the current cost-effectiveness of the Guidelines and ways in which that might be enhanced. Participants found the question of cost-effectiveness difficult to answer without budget or benchmarking information. However there was a widespread perception that there were some high-cost activities in the development of the Guidelines that might be undertaken at a lower cost, thus freeing up funds for other features. Those activities were:

- Extensive paper distribution of the draft and complete Guidelines – this was seen as unnecessary in an era of multiple online options (see Chapter 8)
- Public consultation for each revision – this was seen as unnecessary given viable and effective alternatives (see Chapter 10)
- The double peer review process, which was seen as duplicating activity (see Chapter 10)
- Undertaking a comprehensive evidence review, versus purchasing that information from overseas or co-funding through a collaboration with an overseas agency. Many participants noted that the Nutrient Reference Values are already undertaken successfully as a collaboration with the Australian health authorities, and saw that as a viable model for collaborating with Australia to undertake a comprehensive evidence review of core information, which would be augmented by information specific to New Zealand (e.g. based on differences in audiences, demographics, soil types).

Areas where many participants preferred to see funds spent were:

- Increased project management and governance resource
- More comprehensive and targeted promotion of the Guidelines
- Development of practical resources for target audiences

- Greater use of visual formats for information, including visual materials already developed elsewhere, to the extent relevant and available (e.g. not subject to copyright, or able to be purchased from other countries)
- Better hyperlinking of the Guidelines to existing research and publications, including locally developed resources (e.g. those of Te Hotu Manawa Māori, Auckland Regional Public Health Service [ARPHS], Pacific Island Food and Nutrition Advisory Group [PIFNAG], Agencies for Nutrition Action [ANA], Diabetes NZ, the Heart Foundation, and the various DHBs and PHOs)
- Employment of subject experts to write materials
- Inclusion of more information for diverse ethnicities
- Monitoring of use of the Guidelines to determine both effective practice use and gaps in use.

Each of these suggestions is covered in detail in earlier chapters or in the following chapters. Many participants also suggested that the Ministry might invite contributions from or joint ventures with relevant local agencies in compiling the Guidelines, to enhance the use of available funding, the relationships between those agencies and the Ministry, and the alignment of information and materials across the sector. Several interview participants also commented that the funds might be spent more or as effectively better on other strategies to achieve the same goals, such as more stringent regulation and auditing of nutrient levels (e.g. sugar, fat and sodium levels) in commercially distributed foods.

Comparative costs

Information on ballpark costs was obtained from only one overseas agency and was provided in confidence. It has been provided to the Ministry separately.

Evaluation participants were not able to identify another set of guidelines developed in New Zealand that they saw as similar in scope to the Food and Nutrition Guidelines for benchmarking purposes.

12. Future directions

Summary conclusions

The evaluation findings indicate that the Guidelines are valued highly by the broad range of health practitioners who use them and are seen by many as essential to safe practice for all health practitioners who provide advice or education in nutrition. Evaluation participants were unanimous in their view that the Guidelines need to be retained, albeit in a form that is more accessible to the range of health practitioners and others and updated more frequently. Common feedback from evaluation participants was that the Guidelines would be improved by a comprehensive revision in terms of their: focus and content; formats, layout and presentation; review processes; distribution and promotion; management and governance structures; and a clearer understanding of their purposes and goals. A model is proposed that was seen widely as a potentially significant improvement on the current Guidelines and likely to reduce or avoid many of the current issues with the features and development of the Guidelines.

A suggested model for the Guidelines

Collating the views of various stakeholders, including the responses of interview participants to some alternatives suggested¹², the following model was seen widely as a potentially significant improvement on the current Guidelines and likely to reduce or avoid many of the current issues with the features and development of the Guidelines. The key features of the suggested model were as follows:

The Guidelines

- Restructure the Guidelines into one key document supported by a cluster of other documents, as has been done in the US and Australia
- Focus the key document on highly visual, practical dietary information that is focused on food (versus nutrients) and on enabling good nutrition, and is thus more accessible to the broad range of target audiences, including health practitioners and others without tertiary health qualifications
- Suggested order of material in the key document was – purposes of the Guidelines; why Guidelines are needed; what they can help with; 5-6 key messages on diet and health; healthy foods, portions and meal suggestions; less healthy foods; age and culture-specific information and advice; diet and medical conditions; practical advice, resources and hyperlinks to other resources; related information (e.g. weight management, activity and fitness)
- Support documents would include:
 - ✧ A background document with the evidence base on the technical and clinical aspects of nutritional and dietary advice
 - ✧ A cluster of short papers that set out information for specific populations based on demographics (age, culture) and other relevant parameters (e.g. disability, medical conditions, dietary preferences [e.g. vegan, kosher, halal])
 - ✧ A range of publications via multiple media, as appropriate to target audiences, with resources aimed at the general public and professionals across all relevant sectors (e.g. healthy plates; menus; recipes; weight management advice; resources of various kinds; hyperlinks to a broad range of online resources)

¹² Through iterative interview methodology, as alternatives emerged in interviews they were ‘concept-tested’ with subsequent interview participants.

- Consultation with relevant stakeholder agencies for best collaborative use of the budgets available and to build on one another's work

Governance

- A Steering Group comprising relevant key stakeholder representatives, meeting regularly to determine the direction and scope of Guidelines development

Distribution and promotion

- Move to a primarily or totally online distribution system
- Development of a separate website for the Guidelines
- Development of a comprehensive distribution and promotions strategy
- Distribution and promotion via a broad range of media
- Materials able to be printed at low cost (e.g. black and white) and kept in a ringbinder format

Review and revision

- Following establishment of the new Guidelines model above, the Steering Group would determine annually an agreed programme of revision for the next 2-3 years, with the focus on priority topics with a short half-life, and identify topics for early revision
- Selected topics would be revised and rewritten by selected topic experts
- Revised topic papers would undergo a single peer review process and be disseminated via online distribution media in a 'modular' form as addenda to or replacements of selected sections of the various Guidelines publications.

In terms of the naming of the Guidelines, while interview participants were happy with referring to them as 'Guidelines', some people suggested that it may be useful to refer to the Guidelines as 'dietary' guidelines, since that term is used internationally. Several evaluation participants also suggested that, to avoid confusion, the advisory information in the Guidelines be referred to as 'standards' rather than 'policy', seeing policy as representing the principles that underlie advice, while standards reflect the interpretation or implementation of policy.

Steps to redevelopment of the Guidelines

A component of the contract for this evaluation was the redevelopment of the programme logic for the Guidelines. Programme logics can be developed either retrospectively (to highlight the gaps in logic of the programme) or prospectively, to assist in the development of the programme or strategy. The most valuable use of this aspect of the evaluation budget, we believe, is to work with the Ministry to develop a programme logic for the *redevelopment* of the Guidelines¹³.

Using a programme logic framework, the steps to redeveloping the Guidelines would be as follows:

- *Clarify the purposes of the Guidelines*
- *Identify key audiences – 'primary' and other*
- *Identify specific outcomes goals for each of those purposes and audiences*
- *Identify content – essential and desirable/non-essential*
- *Identify structure, layout and presentation*
- *Determine best process for compilation*

¹³ Doing this would involve an additional cost for a return flight Auckland to Wellington.

- *Determine distribution model and strategy – range of modes and media*
- *Identify promotion requirements and develop a promotion strategy*
- *Determine the most appropriate governance and management structure and resources*
- *Identify other essential resources and how to access or develop them*
- *Determine the budget*
- *Undertake a risk assessment and develop a risk management strategy.*

Draft outcomes parameters for assessing the effectiveness of the Guidelines

A further component of the evaluation contract was to “compile a set of draft parameters that will constitute the long-term outcomes objectives for the Guidelines, and will be included in the revised programme logic, and can be used as the basis for a future evaluation of the long-term outcomes of the Guidelines”. If the Guidelines are to be redeveloped along the lines suggested earlier, or in any other significant way, then the outcomes parameters should be developed after that point, to ensure that they are relevant.

Even if the Guidelines are not significantly redeveloped, it is recommended that the strategy that underlies their production be developed further via development of a comprehensive programme logic, including the clarification of the specific outcomes goals for the Guidelines. The outcomes parameters for monitoring and evaluating effectiveness would then be based on those outcomes goals.

Broadly speaking, the following parameters have emerged from the evaluation as constituting the features on which evaluation participants assessed the value of the Guidelines to them:

- *Extent of **uptake** across:*
 - *Targeted professions and sectors*
 - *Geographic areas*
 - *Professionals in diverse ethnic groups*
- *Main **reasons for use** (e.g. education, information, safe practice, compliance)*
- ***Types of usage** across professions and sectors (e.g. to create or inform policy; to create resources of various kinds; in undergraduate, postgraduate and continuing professional education; to develop standards)*
- ***Ease of access***
- ***Relevance and suitability** to diverse target audiences of:*
 - ***Content** (focus, scope, comprehensiveness, currency, accuracy, strength of the evidence base, cultural relevance)*
 - ***Presentation** (layout, formats, readability, utility, cultural relevance)*
 - ***Distribution** (formats, media, accessibility, cultural relevance)*
 - ***Promotion** (reach, media, cultural relevance)*
- ***Effectiveness of distribution and promotion***
- ***Responsiveness to stakeholder needs***
- ***Impacts in terms of specified outcomes goals.***

Appendix 1: Areas of inquiry

Process evaluation questions

Aims and focus

- Are there clear aims for all Guidelines? Are the aims appropriate? Do they need to be modified?
- Strategic rationale – content, purpose, intended outcomes

Compilation and revision

- Is there a standard process for developing/reviewing the Guidelines?
- Are there timelines in place for development of Guidelines?
- Is the project planning process optimal?
- How systematic/robust is the process for developing the Guidelines?
- Is the stakeholder consultation done at the beginning of the Guidelines development process useful?
- Are the Guidelines sufficiently evidence-based? What level of evidence is deemed acceptable? Is the process used to gather and evaluate evidence appropriate?
- Is the peer-review process adequate?
- How effective is the consultation process?
- How could the process of developing the Guidelines be improved?
- Who are the key stakeholders involved in development and planning of Guidelines? Is that range of stakeholders sufficient?
- What are the key sources of national and international data and information?
- What are the key success factors in planning and development of the Guidelines?
- How are stakeholders informed about the Guidelines development process?
- At what stage and level are various stakeholders involved in the Guidelines development process?
- What are the key facilitators to successful stakeholder consultation?

Outcome evaluation questions

Access, awareness and promotion

- Who is currently using the Guidelines? Who is not? Why?
- Are those who need or should have access to the guidelines accessing them? If not, why not?
- What media are used for dissemination? How appropriate are they?
- Promotion/marketing
 - a. How are the guidelines promoted/marketing throughout the health sector?
 - b. Where did stakeholders learn of Guidelines?
 - c. How beneficial was initial information about the Guidelines?
- Are there ways that access could be enhanced or improved?

Presentation

- How user-friendly/appropriate is the format/layout? language? visuals?
- How easy is it to find the information that users want (searchability)?

Content and scope

- What information areas are of most interest/use? Why?

- Is the scope with regard to nutrition issues appropriate? If not, in what ways?
- Is information at the appropriate level and relevant (practicality)?
- How robust is the information? Is it adequately evidence-informed?
- Is information up-to-date? Should the frequency of updates be changed, and if so how?
- Are there topics that should be covered by the Guidelines that are not currently covered (gaps)? If so, what is the rationale for these?
- Should physical activity continue to be included in the Guidelines as it is currently, or should it be separate? For what reasons?
- If physical activity is included in the Guidelines, is the current level of physical activity information appropriate? If not, how could it be improved?
- How appropriate are the Guidelines for specific population groups, particularly health providers working with Māori, Pacific, and Asian people?

Uses and impacts

- Do the Guidelines have the potential to reduce inequalities?
- How and when are the Guidelines being used by health practitioners and stakeholder organisations, e.g. policies, education sessions, teaching plans, presentations, protocols?
- Have the Guidelines influenced policy change in stakeholder organisations?
- In what ways have the Guidelines been most valuable and in what situations?
- Impacts
 - a. What have been some of the impacts from using the Guidelines?
 - b. Has there been improvements in stakeholder food and physical activity knowledge?
 - c. Are agencies using the Guidelines in developing their policies, and/or in staff training, protocols, or other aspects of their services? (see the Draft Logic Model)

Future options

- Should the Guidelines continue to be produced? Should they continue to be called Guidelines or are other terms more appropriate e.g. position statements?
- How could the Guidelines be improved in terms of format, content and process?
- What are the costs involved with different approaches/options to developing and presenting the Guidelines, and resource within New Zealand (e.g. expertise)?

Appendix 2: Data collection

Methods

A mixed method approach integrated data obtained from the following methods:

➤ <i>Literature/evidence review and analysis</i>
➤ <i>Document review</i>
➤ <i>Key informant interviews</i>
➤ <i>Stakeholder interviews</i>
➤ <i>E-survey</i>

Documentation review

Documents reviewed include:

- Background documents, including plans for the design and intent of the Guidelines
- Ministry policy and strategy documents in relation to the Guidelines
- Materials generated in the production of the Guidelines
- Internal reviews of the Guidelines to date

The document review focused on:

- The history of the development of the Guidelines Series up till the present
- Rationale for the various components and features of the Guidelines
- Enablers and barriers in delivery and implementation of the Guidelines.

Literature/evidence review

Topics for the evidence review were:

Health practitioner guidelines – development

- What is the range of ways that health ministries provide F&N guidelines to health practitioners?
 - a. Format/layout/design of information/materials (topics; parameters; category systems, etc.)
 - b. Dissemination
- How frequently are F&N guidelines revised or updated? What processes are typically used for that process (e.g. research; analysis; sector consultation)?
- What factors or processes facilitate compilation and dissemination?
- What are the barriers to effective compilation?
- What are the barriers to effective uptake?

Health practitioner guidelines – effectiveness

- How effective are the current methods used (compilation of content and dissemination) for engaging health practitioners in using/applying F&N guidelines?
- Which methods are most effective in promoting awareness, uptake and utilisation?
- What is the range of ways in which F&N guidelines are used? Why?
- What are they used for most often? Why?
- What kinds of health practitioners use them most? Least? Why?

- Which aspects or features of F&N guidelines do practitioners find most valuable (e.g. content areas; design)? Why?

Materials were sourced from:

- An internet and library search
- Materials used by the Ministry in recent revisions of the Guidelines
- Overseas Ministry/government and other agencies' websites
- Materials obtained from key informants.

A topline literature review report has been provided to the Ministry separately.

Stakeholder interviews

Interviews were with individuals or in small 'affinity' groups undertaken face-to-face in Auckland and Wellington at participants' usual place of work, and by telephone with people outside of those locations. They were based on semi-structured topic guides developed for each stakeholder group, covering topics identified as relevant by the evaluation team and the Ministry's Contract Manager.

Interview sample

Table 2: Interview sample		
Stakeholder	Total number	Interview medium ¹⁴
Guidelines designers and implementation personnel		
Ministry personnel (current and previous)	6	Face to face
Contract personnel	3	Face to face
Stakeholder agencies		
Provider organisations	11	Face to face or phone
Professional associations	7	Face to face or phone
Advisory agencies/groups ¹⁵	13	Face to face or phone
Tertiary institutions teaching dietitian and nutritionist qualifications	8	Face to face or phone
Other stakeholders		
Health practitioners who rarely used the Guidelines	3	Phone
Overseas key informants	2	Phone
Other stakeholders (e.g. central government; food industry)	2	Phone
Total evaluation participants	55	

Sampling ensured a representation of participants in terms of:

- Culture (Māori, Pacific, other migrant cultures)
- Location (e.g. NZ-wide, including metropolitan, provincial and remote/rural, and including practitioners working in communities with nutritionally at-risk populations)

¹⁴ Evaluation participants located in the Auckland, Wellington and Bay of Plenty regions (locations where evaluation team members are based) were interviewed in person. Those in other locations were interviewed by telephone.

¹⁵ Te Hotu Manawa Māori, Pacific Island Food and Nutrition Advisory Group, National Heart Foundation, Age Concern, Cancer Society, Fitness New Zealand, Nutrition Foundation, Fight the Obesity Epidemic.

- Health practitioner role
- Type of organisation
- Years of experience in health practice.

Recruitment and communication

All recruitment was undertaken by members of the evaluation team. A letter was sent from the Ministry to all relevant stakeholders providing information about the purposes of the evaluation and encouraging participation (**Appendix 3**).

E-survey

Questionnaire content

A questionnaire (**Appendix 4**) was developed into an online survey with questions around:

Process questions

- Ratings of aspects of development of the Guidelines, in particular the consultation process
- ‘Best things’ about the development process
- Suggested areas for improvement

Outcome/impacts questions

- Awareness and accessibility of the Guidelines
- Content (relevance, including cultural relevance; scope; accuracy; limitations)
- Presentation (e.g. layout; formats; language used; cultural appropriateness)
- Dissemination (e.g. dissemination media)
- Potential and observed impacts of the Guidelines
- Future options (value; improvements)

Demographic questions – to allow for comparisons, e.g.:

- Respondent’s culture
- Type of health practitioner role
- Location
- Type of community/population serviced
- Years of experience in the health sector.

A draft questionnaire was developed in consultation with the Ministry and piloted with four health practitioners representative of the target group, including people from a range of cultures as relevant.

Survey dissemination

An invitation to take part in the survey was disseminated through 14 agencies, including professional associations, advocacy groups and Māori and Pacific provider agencies, identified so as to ensure that the invitation went to as broad a range of health practitioners as possible. The agencies were¹⁶:

- Plunket
- Dietitians New Zealand

¹⁶ Two other agencies approached – Fitness New Zealand and the New Zealand Dental Association – did not circulate the invitation to their members.

- Nutrition Society of New Zealand
- Royal New Zealand College of General Practitioners (RNZCGP)
- New Zealand Nurses Organisation (NZNO)
- New Zealand College of Midwives (NZCOM)
- Pharmaceutical Society
- Agencies for Nutrition Action (ANA)
- Te Hotu Manawa Māori
- Pacific Island Food and Nutrition Advisory Group (PIFNAG)
- Procure PHO
- Wellchild New Zealand
- Whitireia Polytechnic School of Nursing
- Kōkiri Marae Health & Social Services.

The invitation (**Appendix 5**) invited people to complete the survey online and entered those doing so into a prize draw. People were given 12 working days to engage in the survey. A reminder email was disseminated through the same agencies one week prior to the survey closing.

Survey response

	N=	% of total respondents	% of total respondents answering questions 10 onwards#
Pharmacist	252	26	14
Dietitian	132	14	19
Health promoter	129	13	15
Nurse	64	7	7
Community health worker	62	6	6
Nutritionist	52	5	7
Academic/researcher	47	5	6
Educator/teacher	38	4	4
Doctor	29	3	2
Midwife/lactation consultant	27	3	3
Personal trainer	6	1	1
Dental professional	3	*	*
Other	130	13	14
Base	971	971	668

Note that the opinion questions started at Q 10 in the survey. Prior to Q 10, respondents were progressively screened out if they (1) had been unaware of the Guidelines prior to responding to the survey or (2) were unaware of how to access the Guidelines. Respondents were screened from answering some later opinion questions relevant to specified aspects of the Guidelines if they (3) had indicated that they had no experience of those Guidelines. Numbers of respondent for each question are given in **Table 5**.

Table 4: Survey response rate by area of work			
	N=	% of total respondents	% of total respondents answering questions 10 onwards
Retail pharmacy	176	18	10
Community health	146	15	16
Hospital	107	11	11
Primary care	102	11	11
Public health	94	10	12
Maori health	79	8	9
Tertiary education/research	56	6	7
Primary/secondary education	32	3	4
Pacific health	28	3	3
Maternity services	25	3	3
Fitness	24	3	3
Elder care	14	1	1
Dental health	3	*	*
Migrant health	3	*	*
Other	83	9	9
Base	969	969	668

Table 5: Number of respondents per survey question		
Question	Base = Respondents who ...	N=
Q.1 In which <u>one</u> of the following health services roles do you <u>mostly</u> work?	Responded to the survey invitation	971
Q.2 Which of the following best describes the area you <u>mostly</u> work in?	Responded to the survey invitation	969
Q.3 Which DHB area do you work in?	Responded to the survey invitation	969
Q.4 What is your ethnicity?	Responded to the survey invitation	955
Q.5 How many years <u>in total</u> have you worked in the health sector?	Responded to the survey invitation	955
Q.6 Before responding to this survey, were you aware of the Ministry of Health's Food and Nutrition Guidelines ?	Responded to the survey invitation	955
Q.7 Do you know how to access the Guidelines documents?	Had been aware of the Guidelines previously	792
Q.8 Which of the Guidelines have you used within the past 12 months?	Knew how to access the Guidelines	668
Q.9 And which of those Guidelines have you used most often ?	Had used the Guidelines in the past 12 months	421
Q.10 Thinking of the Guidelines document that you use most often, roughly how often do you use it?	Had used the Guidelines in the past 12 months	419
Q.11 And still thinking of the Guidelines document that you use most often, roughly how much of the information in that document have you read?	Had used the Guidelines in the past 12 months	419
Q.12 Thinking of the Guidelines document that you	Had used the Guidelines in the	419

Table 5: Number of respondents per survey question		
Question	Base = Respondents who ...	N=
use most often, roughly how often do you use it?	past 12 months	
Q.13 And still thinking of the Guidelines document that you use most often, roughly how much of the information in that document have you read?	Had used the Guidelines in the past 12 months	419
Q.14 How often in the past two years have you used information in the Guidelines generally, for each of the following purposes?	Knew how to access the Guidelines	633
Q.15 Thinking about the Guidelines overall, what would you say is the <u>greatest value</u> of these Guidelines for you?	Knew how to access the Guidelines	617
Q.16 In what medium do you usually access the Guidelines?	Knew how to access the Guidelines	617
Q.17 How adequate do you find the information in the Guidelines in each of the following ways?	Knew how to access the Guidelines	608
Q.18 What areas of information in the Guidelines have you found <u>most</u> valuable? (OPEN)	Knew how to access the Guidelines	574
Q.19 Are there any important gaps in the areas of information in the Guidelines? What's missing?	Knew how to access the Guidelines	573
Q.20 How satisfactory are the following aspects of the <u>presentation</u> of the Guidelines?	Knew how to access the Guidelines	570
Q.21 Are there any aspects of <u>the presentation</u> of the Guidelines that could be improved? (OPEN)	Knew how to access the Guidelines	570
Q.22 Currently the Guidelines are reviewed via a 'rolling review' process, on average approximately once every 10+ years, and the revised draft disseminated for public consultation before being finalised and published. Were you aware of this consultation process for the Guidelines?	Knew how to access the Guidelines	569
Q.23 Have you ever made a submission on a draft Guidelines document?	Were or might have been aware of the consultation process	242
Q.24 Was that process useful for you?	Had made a submission	99
Q.25 In your view, is it necessary for the draft Guidelines to go to broad public consultation, rather than targeted health sector input?	Knew how to access the Guidelines	569
Q.26 Are there any particular barriers to you or your profession taking part in the Guidelines revision process? (OPEN)	Knew how to access the Guidelines	568
Q.27 Do you have any suggestions for improving the Guidelines revision process, as outlined below? (OPEN)	Knew how to access the Guidelines	568
Q.28 Considering the future development of the Guidelines, in what ways could the Food and Nutrition Guidelines be made more useful <u>for you or your profession?</u> (OPEN)	Responded to survey	833
Q.29 And finally, in what medium would you prefer to receive the Guidelines?	Responded to survey	833

Appendix 3: Stakeholder letter

[Ministry of Health letterhead]

20 May 2011

Invitation to take part in the Evaluation of the Food and Nutrition Guidelines

Tēnā koe

About the evaluation

The [Food and Nutrition Guidelines Series](#) consists of five documents that aim to provide up-to-date, evidence informed policy advice and technical information for health practitioners working with the public to achieve a healthy lifestyle. The Ministry has been publishing these Guidelines for many years, and it is timely now to evaluate their effectiveness. A team of independent researchers experienced in health sector evaluation and research, Pam Oliver & Associates, has been contracted to undertake the evaluation.

Taking part in the evaluation

To assess the effectiveness of the Guidelines, feedback is needed from the broad range of health practitioners for whom they are designed. You and your organisation have been identified as a key stakeholder. We would really value your input, whether or not you have been aware of the Guidelines or use them. This is your opportunity to help shape the Guidelines for the benefit of current and future health practitioners.

The interviews

A member of the evaluation team will be contacting you, along with other selected key stakeholder organisations, over the next couple of weeks to arrange a time to talk. Interviews will take around 30-45 minutes, will be undertaken either in person or by phone, and will be completely confidential. You are welcome to include a colleague in the interview.

In addition to key stakeholder interviews, an E-survey will be distributed to a wide range of frontline health practitioners to obtain diverse perspectives on the effectiveness of the Guidelines.

Participants' ethical protections

The identity of all participants will remain confidential to the evaluators, and evaluation reporting will ensure participants' anonymity. You can decline to answer particular questions if you wish without giving a reason, and you can withdraw from an interview if you choose at any time. You will be given access to a copy of the summary of findings once the evaluation has been completed.

If you would like more information about the evaluation, please feel welcome to contact:

- Pam Oliver, Evaluation Manager (09 372 7749 / pamo@clear.net.nz)
- Louise McIntyre, Advisor Nutrition, Ministry of Health (04 8163382 / Louise_McIntyre@moh.govt.nz)

We really appreciate your help for the Ministry in this way.

Kind regards



Harriette Carr
Public Health Medicine Specialist / Senior Advisor
Nutrition and Physical Activity Team
Clinical Leadership, Protection, and Regulation Business Unit
Ministry of Health

Appendix 4. Questionnaire

Ministry of Health Food & Nutrition Guidelines - Aug 2011

Q.1 Introduction

The Ministry of Health's **Food and Nutrition Guidelines Series** consists of six documents that aim to provide up-to-date, evidence informed policy advice and technical information for health practitioners working with the public to achieve a healthy lifestyle. The Ministry has been publishing these Guidelines for many years, and it is timely now to evaluate their effectiveness.

*Your answers are completely anonymous. The section at the end for your email address is only for the purposes of informing you if you are one of the winners of the **prize draw of two \$100 Prezzy Cards.***

Thank you for contributing your time and views.
Pam Oliver, Evaluation Manager 09 3727749

Q.2 In which one of the following health services roles do you mostly work?

[Click one]

- ☐ 01 Academic/Researcher
- ☐ 02 Community health worker
- ☐ 03 Dental professional
- ☐ 04 Dietitian
- ☐ 05 Doctor
- ☐ 06 Educator/Teacher
- ☐ 07 Health Promoter
- ☐ 08 Midwife/Lactation consultant
- ☐ 09 Nurse
- ☐ 10 Nutritionist
- ☐ 11 Personal Trainer
- ☐ 12 Pharmacist
- ☐ 13 Other - please specify

Q.3 other13

Q.4 Which of the following best describes the area you mostly work in? *[Click one]*

- ☐ 01 Community health
- ☐ 02 Dental health
- ☐ 03 Elder care
- ☐ 04 Fitness
- ☐ 05 Hospital
- ☐ 06 Maori health
- ☐ 07 Maternity services
- ☐ 08 Migrant health
- ☐ 09 Pacific health
- ☐ 10 Primary care
- ☐ 11 Primary/Secondary Education
- ☐ 12 Public Health
- ☐ 13 Retail pharmacy
- ☐ 14 Tertiary Education /Research
- ☐ 15 Other

Q.5 Which DHB area do you work in? *[Click one]*

- ☐ 01 Auckland
- ☐ 02 Bay of Plenty
- ☐ 03 Canterbury
- ☐ 04 Capital & Coast
- ☐ 05 Counties Manukau
- ☐ 06 Hawkes Bay
- ☐ 07 Hutt Valley
- ☐ 08 Lakes

- ☐ 09 MidCentral
- ☐ 10 Nelson Marlborough
- ☐ 11 Northland
- ☐ 12 South Canterbury
- ☐ 13 Southern
- ☐ 14 Tairāwhiti
- ☐ 15 Taranaki
- ☐ 16 Waikato
- ☐ 17 Wairarapa
- ☐ 18 Waitemata
- ☐ 19 West Coast
- ☐ 20 Wanganui

Q.6 What is your ethnicity? *[Click all that apply]*

- ☐ 1 NZ European
- ☐ 2 Māori
- ☐ 3 Pasifika
- ☐ 4 Asian
- ☐ 5 Middle Eastern/Latin American/African
- ☐ 6 Other

Q.7 How many years in total have you worked in the health sector? *[Click one]*

- ☐ 1 Less than 1 year
- ☐ 2 1-2 years
- ☐ 3 3-5 years
- ☐ 4 6-10 years
- ☐ 5 More than 10 years

Q.8 Before responding to this survey, were you aware of the Ministry of Health's **Food and Nutrition Guidelines**? *[Click one]*

- ☐ 1 Yes
- ☐ 2 No
- ☐ 3 Not sure

Q.9 Do you know how to access the Guidelines documents? *[Click one]*

- ☐ 1 Yes
- ☐ 2 No
- ☐ 3 Not sure

[S - IF THE ANSWER IS 2, THEN SKIP TO QUESTION 32]

Q.10 Which of the Guidelines have you used within the past 12 months? *[Click all that apply]*

- ☐ 1 Infants and Toddlers (0-2)
- ☐ 2 Children (2-12)
- ☐ 3 Adolescents
- ☐ 4 Pregnant and Breastfeeding Women
- ☐ 5 Adults
- ☐ 6 Older People
- ☐ 7 None

[S - IF THE ANSWER IS 7, THEN SKIP TO QUESTION 16]

Q.11 And which of those Guidelines have you used **most often**? *[Click one]*

- ☐ 1 Infants and Toddlers (0-2)
- ☐ 2 Children (2-12)
- ☐ 3 Adolescents
- ☐ 4 Pregnant and Breastfeeding Women
- ☐ 5 Adults
- ☐ 6 Older People
- ☐ 7 None

[A - IF THE ANSWER TO QUESTION 11 IS 7, THEN SKIP TO QUESTION 14]

Q.12 Thinking of the Guidelines document that you use **most** often ([RESPONSE 1 TO Q. 10]),
roughly how often do you use it? *[Click one]*

- ☐ 1 At least once a week
- ☐ 2 About once a month

- ☐ 3 About once every 2-3 months
☐ 4 About once or twice a year
☐ 5 Less than once a year

Q.13 And still thinking of the Guidelines document that you use **most** often ([RESPONSE 1 TO Q. 10]), roughly how much of the information in that document have you read? *[Click one]*

- ☐ 1 Most or all
☐ 2 Half or more
☐ 3 Less than half
☐ 4 Relatively little

Q.14 Thinking of the Guidelines document that you use **most** often ([ANSWER TO Q. 11]), roughly how often do you use it? *[Click one]*

- ☐ 1 At least once a week
☐ 2 About once a month
☐ 3 About once every 2-3 months
☐ 4 About once or twice a year
☐ 5 Less than once a year

Q.15 And still thinking of the Guidelines document that you use **most** often ([ANSWER TO Q. 11]), roughly how much of the information in that document have you read? *[Click one]*

- ☐ 1 Most or all
☐ 2 Half or more
☐ 3 Less than half
☐ 4 Relatively little

Q.16 How often **in the past two years** have you used information in the Guidelines generally, for each of the following purposes?
[Click one answer in every row]

	How often have you used them?			
	Never	1-2 times	3-6 times	>6 times
Checking on the accuracy or currency of your knowledge, on an 'as needs' basis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (81)
Providing dietary advice to patients/clients/schools/other groups	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (82)
Creating informational brochures, guidelines or articles/news reports for clients or the public	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (83)
Educating colleagues or students (e.g. staff training, professional education courses, staff toolkits)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (84)
To make sure that you are complying with Ministry of Health advice or recommendations	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (85)
For developing organisational policy, standards and/or procedures	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (86)
Referring others to accurate nutritional information	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (87)
As evidence to support submissions or lobbying	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (88)
Other - please describe	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (89)

Q.17 other9

Q.18 Thinking about the Guidelines overall, what would you say is the greatest value of these Guidelines for you? *[Type in the box]*

Q.19 In what medium do you usually access the Guidelines? *[Click all that apply]*

- ☐ 1 Hard copy
☐ 2 Electronic
☐ 3 Other way - please describe

Q.20 other3

Q.21 How adequate do you find the information in the Guidelines in each of the following ways?
[Click one in every row]

	How adequate?			
	Not very	Somewhat	Mostly	Not sure
Accessible - easy to find	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2293)
Relevant to your profession or role	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2294)
Relevant to your client base	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2295)
Comprehensive in scope	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2296)
Culturally relevant	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2297)
Up to date	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2298)
Generally accurate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2299)
Evidence-based	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2300)
Easy to understand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2301)
Easy to apply in your role	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2302)
	Not very	Somewhat	Mostly	Not sure
Practically oriented	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2303)

	How adequate?			
	Not very	Somewhat	Mostly	Not sure
Referenced to sources of information	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 (2304)

Q.22 What areas of information in the Guidelines have you found most valuable? *[Type in the box]*

Q.23 Are there any important gaps in the areas of information in the Guidelines? What's missing?
[Type in the box, click NEXT to continue]

Q.24 How satisfactory are the following aspects of the presentation of the Guidelines? *[Click one on every row]*

	How satisfactory is the presentation?				
	Not at all satisfactory	Somewhat satisfactory	Moderately satisfactory	Mostly satisfactory	Not sure
Language user-friendly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6305)
Layout logical	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6306)
Language culturally relevant	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6307)
Use of visual formats sufficient (e.g. tables, diagrams)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6308)
Easy to find the information sought	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6309)
Index adequate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6310)
	Not at all satisfactory	Somewhat satisfactory	Moderately satisfactory	Mostly satisfactory	Not sure
Table of contents easy to follow	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 (6311)

Q.25 Are there any aspects of the presentation of the Guidelines that could be improved? *[Type in the box, click NEXT to continue]*

Q.26 Currently the Guidelines are reviewed via a 'rolling review' process, on average approximately once every 10+ years, and the revised draft disseminated for public consultation before being finalised and published. Were you aware of this consultation process for the Guidelines? *[Click one]*

- ☐ 1 Yes
☐ 2 No
☐ 3 Not sure

[S - IF THE ANSWER IS 2, THEN SKIP TO QUESTION 29]

Q.27 Have you ever made a submission on a draft Guidelines document? *[Click one]*

- ☐ 1 Yes
☐ 2 No

Q.28 Was that process useful for you?
[Click one]

- ☐ 1 Yes
☐ 2 No
☐ 3 Not sure

Q.29 In your view, is it necessary for the draft Guidelines to go to broad public consultation, rather than targeted health sector input? *[Click one]*

- ☐ 1 Yes
☐ 2 No
☐ 3 Not sure

Q.30 Are there any particular barriers to you or your profession taking part in the Guidelines revision process? *[Type in the box]* [SHOW: guidediagram.jpg]

Q.31 Do you have any suggestions for improving the Guidelines revision process, as outlined below? *[Type in the box, click NEXT to continue]*

Q.32 Considering the future development of the Guidelines, in what ways could the Food and Nutrition Guidelines be made more useful for you or your profession? *[Type in the box, click NEXT to continue]*

Q.33 And finally, in what medium would you prefer to receive the Guidelines? *[Click one]*

- ☐ 1 Hard copy
☐ 2 Electronic - MS Word
☐ 3 Electronic - PDF
☐ 4 Other - please describe

Q.34 other4

Q.35 You are now entered into the prize draw for a \$100 Prezzy Card.

Please enter your email address into the box below, so that we will be able to contact you, should you be a winner. **This completes the survey. Thank you so much for your time.**

Appendix 5: Survey invitation

Subject heading: **E-survey for an Evaluation of the Food and Nutrition Guidelines**

Greetings

You are invited to take part in a 10 minute online survey to obtain your feedback on the usefulness and effectiveness of the Ministry of Health's Food and Nutrition Guidelines, to inform their future development. Everyone completing the survey by Wednesday 5 October will be entered into a draw for two prizes of a \$100 Prezzy Card.

The Ministry wishes to get input from a very broad range of people working in public health and related roles. ***We would really value your input, whether or not you have been aware of the Guidelines or use them.***

To complete the short survey, ***click on this link*** <https://secure.dataplus.co.nz/data/guide.htm>

If you would like any further information about the survey, please contact the Evaluation Manager Pam Oliver 09 3727749 / pamo@clear.net.nz

Apologies if you receive this invitation more than once, as it is being distributed by several professional organisations.

The [Food and Nutrition Guidelines Series](#) consists of six documents that aim to provide up-to-date, evidence-informed policy advice and technical information for health practitioners working with the public. The Ministry of Health has been publishing these Guidelines for many years, and it is timely now to evaluate their effectiveness. A team of independent researchers experienced in health sector evaluation and research, Pam Oliver & Associates, has been contracted to undertake the evaluation.

A summary of the evaluation findings will be published on the Ministry of Health website later this year.

Many thanks for assisting the Ministry in this way.

Dr Harriette Carr
Public Health Medicine Specialist (APTP)
Nutrition & Physical Activity Team
Clinical Leadership, Protection and Regulation
Ministry of Health